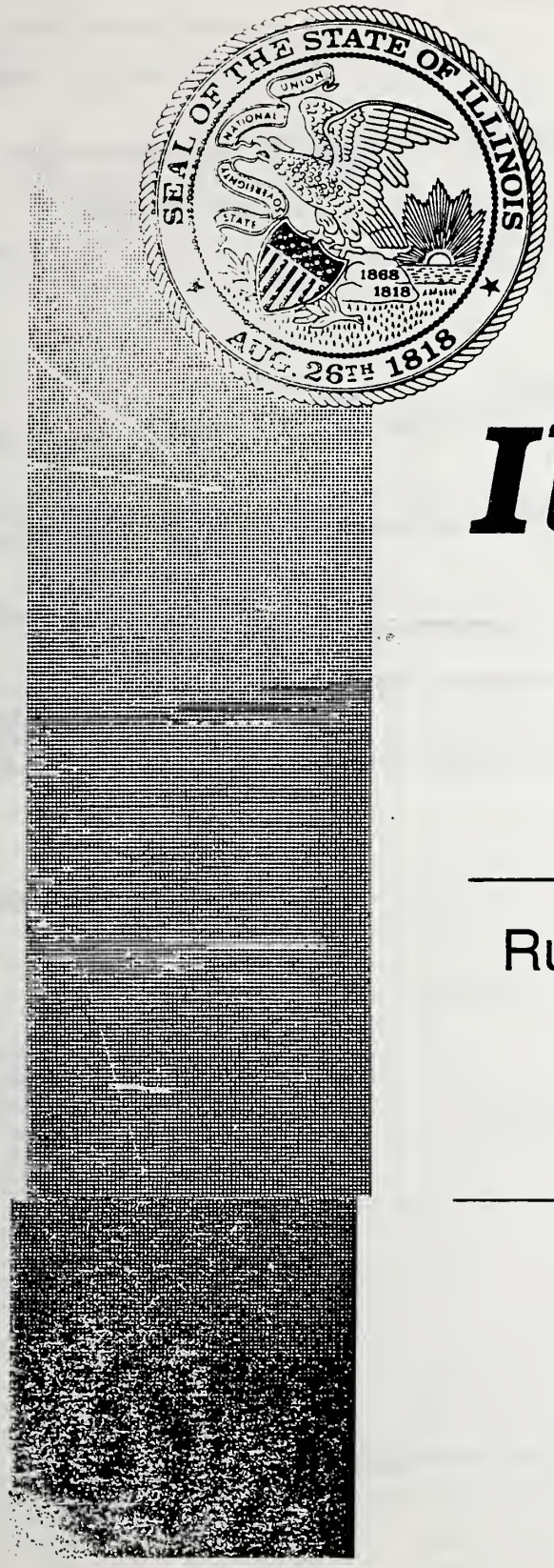

1992

Illinois Register

Rules of Governmental Agencies

Volume 16, Issue 16 — April 17, 1992

Pages 6127-6520

published by

George H. Ryan
Secretary of State

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INTRODUCTION

The Illinois Register is the official state document for publishing public notice of rulemaking activity by State governmental agencies. The table of contents is arranged categorically by rulemaking activity and alphabetically by agency within each category. Rulemaking activity consists of proposed or adopted new rules or amendments to or repealers of existing rules, including those by emergency or peremptory action.

The *Register* also contains Executive Orders and Proclamations issued by the Governor, notices of public information required by State statute, and activities (meeting agendas, Statements of Objection or Recommendation, etc.) of the Joint Committee on Administrative Rules (JCAR), a legislative oversight committee which monitors the rulemaking activities of State agencies. In addition, the *Register* contains a Cumulative Index listing alphabetically by agency the Parts (sets of rules) on which rulemaking activity has occurred in the current *Register* volume and a Sections Affected Index listing, by Title of the *Illinois Administrative Code*, each Section (including supplementary material) of a Part on which rulemaking activity has occurred in the current volume. Both indices are action coded and are designed to aid the public in monitoring rules.

The *Register* will serve as the update to the *Illinois Administrative Code*, a compilation of the rules of State agencies. The most recent edition of the *Code* along with the *Register* comprise the most current accounting of the State agencies' rules.

The *Illinois Register* is the property of the State of Illinois, granted by the authority of the Illinois Administrative Procedure Act (Ill. Rev. Stat. 1991, ch. 127, pars. 1001 et seq., as amended).

REGISTER PUBLICATION SCHEDULE 1992

Material Rec'd after 4:30 p.m. on:	And before 4:30 p.m. on:	Will be in Issue #:	Published on:	Material Rec'd after 4:30 p.m. on:	And before 4:30 p.m. on:	Will be in Issue #:	Published on:
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Please note: When the Register deadline falls on a State holiday, the deadline becomes 4:30 p.m. on Monday *(the day before).*

Printed by authority of the
State of Illinois
April 1992 – 890 – GA-1343

ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED RULES

1) Heading of Part: Procedures for Operation of the Potentially Infectious Medical Waste Transporter Fee System

2) Code Citation: 35 Ill. Adm. Code: 880

3) Section Numbers: Proposed Action:

880.100	New Section
880.101	New Section
880.102	New Section
880.103	New Section
880.104	New Section
880.105	New Section
880.106	New Section
880.200	New Section
880.201	New Section
880.202	New Section
880.203	New Section
880.300	New Section
880.301	New Section

4) Statutory Authority: Section 56.6 of the Environmental Protection Act (Ill. Rev. Stat. 1989, ch. 111 1/2, par. 1056.6, as amended by P.A. 87-752, effective January 1, 1992).

5) A Complete Description of the Subjects and Issues Involved: The Environmental Protection Act ("Act") authorizes the Agency to collect a fee in the amount of 1.5 cents per pound of potentially infectious medical waste ("PIMW") transported in Illinois. This fee is collected from each transporter of PIMW required to have a permit under Section 56.1(f) of the Act and each transporter of PIMW not required to have a permit under Section 56.1 (f)(1)(A) of the Act if the PIMW is transported to a site or facility not owned, controlled, or operated by the transporter.

The Act also authorizes the Agency to adopt rules establishing procedures relating to the collection of the fees. These procedures must include, but not be limited to: (i) necessary records identifying the quantities of PIMW transported; (ii) the form and submission of reports to accompany the payment of fees to the Agency; and (iii) the time and manner of payment of fees to the Agency, which payments shall be not more often that quarterly.

35 Ill. Adm. Code 880 provides procedures relating to the collection of the fees. The proposed rules list the information that must be submitted to the Agency, and the manner and time of payment. In addition, the proposed rules require certification of documents and weight.

6). Will this proposed rule replace an emergency rule currently in effect? No

ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED RULES

7) Does this rulemaking contain an automatic repeal date? ___ Yes _X_ No

If "yes", please specify the date: _____

8) Does this proposed rule (amendment, repealer) contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

Section Numbers	Proposed Action	Illinois Register Citation

10) Statement of Statewide Policy Objectives: These proposed rules do not create or enlarge a state mandate as defined in Section 3(b) of the State Mandates Act (Ill. Rev. Stat. 1989, ch. 85, par. 2203(b)

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on these proposed rules may submit them in writing by no later than 45 days after publication of this notice to:

Susan J. Schroeder
Division of Legal Counsel
2200 Churchill Road
P.O. Box 19276
Springfield, Illinois 62794-9276

12) Initial Regulatory Flexibility Analysis:

A) Date rule was submitted to the Business Assistance Office of the Department of Commerce and Community Affairs: March 24, 1992

B) Types of small businesses affected: All transporters of potentially infectious medical waste (PIMW) are required to pay this fee unless: (i) the transporter is transporting PIMW generated solely by that transporter's activities if the PIMW is transported to a site or facility owned, controlled, or operated by the transporter; or (ii) the transporter transports less than 50 pounds of PIMW per month generated at the same site; or (iii) the fee has been paid by another transporter who previously transported the PIMW. Some hauling/transportation companies will be considered small businesses under the Illinois Administrative Procedure Act definition.

C) Reporting, bookkeeping or other procedures required for compliance: These proposed rules require daily, monthly, quarterly, and supplemental reports. The proposed rules also require certification of documents and weight.

D) Types of professional skills necessary for compliance: The services of a professional engineer or attorney are not required to

comply with the proposed rules. A person with good recordkeeping skills can fill out the reports required by the proposed rules.

The full text of the Proposed Rule begins on the next page:

TITLE 35: ENVIRONMENTAL PROTECTION
SUBTITLE G: WASTE DISPOSAL
CHAPTER II: ENVIRONMENTAL PROTECTION AGENCY

PART 880
PROCEDURES FOR OPERATION OF THE POTENTIALLY INFECTIOUS MEDICAL WASTE TRANSPORTER FEE SYSTEM

SUBPART A: GENERAL PROVISIONS

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880.202 Quarterly PIMW Report
880.203 Supplemental PIMW Report

SUBPART C: PROCEDURES FOR THE PAYMENT OF PIMW TRANSPORTER FEES

Section
880.300 Quarterly Submission of Payment of PIMW Transporter Fee
880.301 Manner of Payment

AUTHORITY: Implementing and authorized by Section 56.6 of the Environmental Protection Act (Ill. Rev. Stat. 1989, ch. 111 1/2, par. 1056.6, et seq., as amended by P.A. 87-752, effective January 1, 1992).

SOURCE: Adopted at ____ Ill. Reg. _____, effective _____.

NOTE: Capitalization denotes statutory language

SUBPART A: GENERAL PROVISIONS

Section 880.100 Applicability

The regulations of this Part apply to transporters of PIMW required to have a permit under Section 56.1(f) of the Act and transporters of PIMW not required to have a permit under Section 56.1(f)(1)(A) of the Act if the PIMW is

transported to a site or facility not owned, controlled, or operated by the transporter.

Section 880.101 Exemptions from PIMW Transporter Fee System

The PIMW transporter fee payment provisions in this Part shall not apply to:

a) transporters of PIMW not required to have a permit under Section 56.1(f)(1)(A) of the Act if the PIMW is transported to a site or facility owned, controlled, or operated by the transporter; or

b) transporters of PIMW who transport less than 50 pounds per month generated at the same site; or

c) transporters where the fee has been paid by another tansporter who previously transported the PIMW.

Section 880.102 Definitions

Except as stated in this Section, the definition of words or terms in this Part shall be the same as those used in the Act.

a) "Act" means the Environmental Protection Act (Ill. Rev. Stat. 1989, ch. 111 1/2, pars. 1001 et seq., as amended by P.A. 87-752, effective January 1, 1992).

b) "Designated facility" means a facility that treats, stores, transfers or disposes of PIMW.

c) "POTENTIALLY INFECTIOUS MEDICAL WASTE" ("PIMW") MEANS THE FOLLOWING TYPES OF WASTE GENERATED IN CONNECTION WITH THE DIAGNOSIS, TREATMENT (I.E., PROVISION OF MEDICAL SERVICES), OR IMMUNIZATION OF HUMAN BEINGS OR ANIMALS; RESEARCH PERTAINING TO THE PROVISION OF MEDICAL SERVICES; OR THE PRODUCTION OR TESTING OF BIOLOGICALS:

1) CULTURES AND STOCKS. THIS WASTE SHALL INCLUDE BUT NOT BE LIMITED TO CULTURES AND STOCKS OF AGENTS INFECTIOUS TO HUMANS, AND ASSOCIATED BIOLOGICALS; CULTURES FROM MEDICAL OR PATHOLOGICAL LABORATORIES; CULTURES AND STOCKS OF INFECTIOUS AGENTS FROM RESEARCH AND INDUSTRIAL LABORATORIES; WASTES FROM THE PRODUCTION OF BIOLOGICALS; DISCARDED LIVE OR ATTENUATED VACCINES; OR CULTURE DISHES AND DEVICES USED TO TRANSFER, INOCULATE, OR MIX CULTURES.

2) HUMAN PATHOLOGICAL WASTES. THIS WASTE SHALL INCLUDE BUT NOT BE LIMITED TO TISSUE, ORGANS, AND BODY PARTS (EXCEPT TEETH AND THE CONTIGUOUS STRUCTURES OF BONE AND GUM), BODY FLUIDS THAT ARE REMOVED DURING SURGERY, AUTOPSY, OR OTHER MEDICAL PROCEDURES; OR SPECIMENS OF BODY FLUIDS AND THEIR CONTAINERS.

3) HUMAN BLOOD AND BLOOD PRODUCTS. THIS WASTE SHALL INCLUDE BUT NOT BE LIMITED TO DISCARDED WASTE HUMAN BLOOD, BLOOD COMPONENTS (E.G., SERUM AND PLASMA), OR SATURATED MATERIAL CONTAINING FREE FLOWING BLOOD OR BLOOD COMPONENTS.

4) USED SHARPS. THIS WASTE SHALL INCLUDE BUT NOT BE LIMITED TO DISCARDED SHARPS USED IN ANIMAL OR HUMAN PATIENT CARE, MEDICAL RESEARCH, OR CLINICAL OR PHARMACEUTICAL LABORATORIES; HYPODERMIC, INTRAVENOUS, OR OTHER MEDICAL NEEDLES; HYPODERMIC OR INTRAVENOUS SYRINGES; PASTEUR PIPETTES; SCALPEL BLADES; OR BLOOD VIALS. THIS WASTE SHALL ALSO INCLUDE BUT NOT BE LIMITED TO OTHER TYPES OF BROKEN OR UNBROKEN GLASS (INCLUDING SLIDES AND COVER SLIPS) IN CONTACT WITH INFECTIOUS AGENTS.

5) ANIMAL WASTE. THIS WASTE SHALL INCLUDE BUT NOT BE LIMITED TO (i) DISCARDED MATERIALS ORIGINATING FROM ANIMALS INOCULATED DURING RESEARCH, PRODUCTION OF BIOLOGICALS, OR PHARMACEUTICAL TESTING WITH AGENTS INFECTIOUS TO HUMANS OR (ii) CARCASSES, BODY PARTS, BLOOD, OR BEDDING OF ANIMALS KNOWN TO HAVE BEEN IN CONTACT WITH AGENTS INFECTIOUS TO HUMANS.

6) ISOLATION WASTE. THIS WASTE SHALL INCLUDE BUT NOT BE LIMITED TO DISCARDED WASTE MATERIALS CONTAMINATED WITH BLOOD, EXCRETIONS, EXUDATES, AND SECRETIONS FROM HUMANS THAT ARE ISOLATED TO PROTECT OTHERS FROM HIGHLY COMMUNICABLE DISEASES. "HIGHLY COMMUNICABLE DISEASES" MEANS THOSE DISEASES IDENTIFIED BY THE BOARD IN RULES ADOPTED UNDER SUBSECTION (e) OF SECTION 56.2 OF THIS ACT.

7) UNUSED SHARPS. THIS WASTE SHALL INCLUDE BUT NOT BE LIMITED TO THE FOLLOWING UNUSED, DISCARDED SHARPS: HYPODERMIC, INTRAVENOUS, OR OTHER NEEDLES; HYPODERMIC OR INTRAVENOUS SYRINGES; OR SCALPEL BLADES.

POTENTIALLY INFECTIOUS MEDICAL WASTE DOES NOT INCLUDE:

1) WASTE GENERATED AS GENERAL HOUSEHOLD WASTE;

2) WASTE (EXCEPT FOR SHARPS) FOR WHICH THE INFECTIOUS POTENTIAL HAS BEEN ELIMINATED BY TREATMENT; OR

3) SHARPS THAT MEET BOTH OF THE FOLLOWING CONDITIONS:

A) THE INFECTIOUS POTENTIAL HAS BEEN ELIMINATED FROM THE SHARPS BY TREATMENT; AND

B) THE SHARPS ARE RENDERED UNRECOGNIZABLE BY TREATMENT. (Section 3.81 of the Act).

d) "Tare weight" means the weight of a reusable shipping container that is not permanently disposed with the PIMW.

e) "Transporter" means a person engaged in the off-site transportation of PIMW by highway or water.

Section 880.103 Retention of Records

Copies of all records required to be kept under this Part shall be retained by the transporter for three years and shall be made available at the transporter's principle place of business in Illinois or corporate headquarters during normal business hours for inspection and photocopying by the Agency.

Section 880.104 Certification of Documents

a) All records and reports retained or submitted to the Agency as required by this Part shall be signed by a person responsible for preparing and reviewing such documents as part of his or her duties in the regular course of business.

b) Any person signing a report submitted to the Agency as required by this Part shall make the following certification:

> I certify under penalty of law that this report and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of the person or persons who manage the system, or those persons directly responsible for gathering the information, the information submitted is, to the best of my knowledge and belief, true, accurate and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fine and imprisonment for knowing violations.

Section 880.105 Certification of Weight

a) Although PIMW may be measured in other units, the transporter is responsible for accurately weighing any load of PIMW in pounds.

b) The PIMW shall be weighed with a device for which certification has been obtained under the Weights and Measures Act (Ill. Rev. Stat. 1989, ch. 147, pars. 101 et seq.).

Section 880.106 Severability

If any Section, subsection, sentence or clause of this Part shall be adjudged unconstitutional, void, invalid or otherwise unlawful, such adjudication shall

not affect the validity of this Part as a whole or any Section, subsection, sentence or clause thereof not adjudged unconstitutional, void, invalid or otherwise unlawful.

SUBPART B: PROCEDURES FOR MAINTAINING RECORDS

Section 880.200 Daily PIMW Report

a) The Daily PIMW Report shall be maintained at the transporter's principal place of business in Illinois or corporate headquarters.

b) The Daily PIMW Report shall be either on a form provided by the Agency or on another form that records the same information.

c) The Daily PIMW Report shall include, but not be limited to, the following information for each load of PIMW transported:

1) the date received;

2) the PIMW transport company name;

3) the permitted medical waste hauler number;

4) the PIMW manifest number;

5) the generator name and location (city/state);

6) the designated facility name and location (city/state);

7) the gross weight in pounds of PIMW subject to the PIMW transporter fee;

8) the gross weight in pounds of PIMW exempt from the PIMW transporter fee and the reason for the exemption;

9) the tare weight in pounds;

10) the net weight in pounds of PIMW subject to the PIMW transporter fee;

11) the net weight in pounds of PIMW exempt from the PIMW transporter fee;

12) the grand totals of gross and net weight of PIMW and the grand total of tare weight;

13) the page subtotal, if applicable; and

14) the authorized name, signature and date.

d) Entries on the Daily PIMW Report shall be made contemporaneously with the receipt of each load unless the transporter uses a different method of recording the required information which assures that required information can be entered on the Daily PIMW Report by the end of each business day, in which case the information must be entered in the Daily PIMW Report by the end of each business day. Where an alternative method of contemporaneous recording is used, that record must be maintained in accordance with the records retention provisions of Section 880.103 of this Part.

Section 880.201 Monthly PIMW Report

a) The Monthly PIMW Report shall be submitted to the Agency on a form provided by the Agency.

b) Entries on the Monthly PIMW Report shall be completed within 10 calendar days after the end of each month.

c) The Monthly PIMW Reports covered by the quarter shall be submitted with the Quarterly PIMW Report to the Agency.

d) The Monthly PIMW Report shall include, but not be limited to, the following information on a daily basis:

1) the month and year received;

2) the PIMW transport company name;

3) the permitted medical waste hauler number;

4) the date PIMW was received;

5) the total number of PIMW manifests used;

6) the net weight in pounds of PIMW subject to the PIMW transporter fee;

7) the grand totals of subsections (d)(5) and (6) of this Section;

8) the certification according to Section 880.104; and

9) the authorized name, signature, date, and telephone number.

Section 880.202 Quarterly PIMW Report

a) The Quarterly PIMW Report shall be submitted to the Agency on a form provided by the Agency.

b) The Quarterly PIMW Report shall include, but not be limited to, the following information:

1) the quarter and year received;

2) the PIMW transport company name and address;

3) the permitted medical waste hauler number;

4) the total number of PIMW manifests used for each of the three months;

5) the net weight in pounds of PIMW subject to the PIMW transporter fee for each of the three months;

6) the total PIMW transporter fee due for each of the three months;

7) the summation of net weight in pounds of PIMW subject to the PIMW transporter fee for the current quarter and for the calendar year;

8) the total PIMW transporter fee due for the current quarter and for the calendar year;

9) the supplemental PIMW transporter fee due or credited for the previous reporting period(s);

10) the PIMW transporter fee due or credited from the previous quarter;

11) the total PIMW transporter fee paid for the quarter;

12) the certification according to Section 880.104; and

13) the authorized name, signature, date, and telphone number.

c) The Quarterly PIMW Report shall be received by the Agency on or before April 15, July 15, October 15 and January 15 of each calendar year and shall cover the three calendar months preceding the receipt date.

d) The PIMW transporter fee required to be paid under Subpart C of this Part shall be included with the submission of the Quarterly PIMW Report. The weight in pounds of PIMW subject to the PIMW transporter fee is required to be listed on each PIMW manifest.

e) The PIMW Quarterly Report, including the payment of the PIMW transporter fee and the applicable Monthly PIMW Reports, shall be sent to the following address:

ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED RULES

Fiscal Services Section
Illinois Environmental Protection Agency
2200 Churchill Road
P.O. Box 19276
Springfield, Illinois 62794-9276

Section 880.203 Supplemental PIMW Report

a) When errors in the amount of PIMW or the amount of the PIMW transporter fee due by month or quarter under this Part are discovered in any of the records required to be kept under this Part, a Supplemental PIMW Report showing the relevant corrections shall be completed by the transporter and submitted to the Agency. The transporter shall show the adjustment on the next Quarterly PIMW Report.

b) The Supplemental PIMW Report shall be submitted to the Agency on a form provided by the Agency.

c) The Supplemental PIMW Report shall include, but not be limited to, the following information:

1) the PIMW transport company name and address;

2) the permitted medical waste hauler number;

3) the PIMW manifest number;

4) the date PIMW was received;

5) the generator name and location (city/state);

6) the designated facility name and location (city/state);

7) the correct net weight in pounds of PIMW;

8) the incorrect net weight in pounds of PIMW previously reported;

9) the difference in weight in pounds of PIMW;

10) the total PIMW transporter fee due or for credit;

11) the grand totals for subsections (c)(7) through (11) of this Section;

12) the page subtotal, if applicable;

13) the certification according to Section 880.104; and

ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PROPOSED RULES

14) the authorized name, signature, date and telephone number.

SUBPART C: PROCEDURES FOR THE PAYMENT OF PIMW TRANSPORTER FEES

Section 880.300 Quarterly Submission of Payment of PIMW Transporter Fee

a) Payment of the $0.015 per pound of PIMW transporter fee required by Section 56.6(a) of the Act shall begin on July 1, 1992. The payment shall be made on a quarterly basis with the submission of the Quarterly PIMW Report. Such payment shall be received by the Agency on or before April 15, July 15, October 15 and January 15 of each year and shall cover the three preceding calendar months.

b) If the calculation of fees under this Section results in an overpayment, the Agency shall credit this overpayment against the PIMW transporter fees due during the next quarter. The Agency shall issue no refunds.

c) If the calculation of fees under this Section results in an underpayment of greater than $10.00, the amount is due to the Agency within 10 calendar days from receipt of an underpayment notice from the Agency.

d) Each transporter shall notify the Agency if it intends to permanently cease transportation of PIMW. This notification shall be received by the Agency within 30 calendar days after ceasing the transportation of PIMW and include:

1) the name and address of the transporter;

2) the date by which PIMW will cease to be transported; and

3) a fee payment schedule to assure submission of fees in accordance with this Part.

e) In the event that a transporter does not transport any PIMW for any quarter, the transporter shall submit the Quarterly PIMW Report to the Agency at the times indicated in subsection (a) of this Section and shall indicate "none" in the appropriate spaces on the Quarterly PIMW Report.

Section 880.301 Manner of Payment

Payment shall be made by money order, cashier's check or certified check payable to the Treasurer, State of Illinois. Payment shall be mailed to the Agency at the following address:

Fiscal Services Section
Illinois Environmental Protection Agency
2200 Churchill Road
P.O. Box 19276
Springfield, Illinois 62794-9276

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED REPEALER

1) Heading of Part: Ingersoll Airport Zoning Regulations

2) Code Citation: 92 Ill. Adm. Code 50

3) Section Numbers: Proposed Action:

50.5	Repeal
50.10	Repeal
50.20	Repeal
50.30	Repeal
50.40	Repeal
50.50	Repeal
50.60	Repeal
50.70	Repeal
50.80	Repeal
50.90	Repeal
50.100	Repeal
50.110	Repeal
50.120	Repeal
50.130	Repeal
50.140	Repeal
50.150	Repeal
50.160	Repeal

4) Statutory Authority: Ill. Rev. Stat. 1981, ch. 15 1/2, par. 48.1 et seq.

5) A complete description of the subjects and issues involved:

By this rulemaking, the Department is repealing Part 50, and elsewhere in this issue of the Illinois Register, is replacing this Part with new rules on the establishment of an airport hazard area in the vicinity of Ingersoll Airport. For a complete description of the differences between the repealed rules and the new rules, please see the Notice of Proposed Rules for Part 50.

6) Will this proposed rulemaking replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed repealer contain incorporations by reference? No

9) Are there any other amendments pending on this Part? No

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED REPEALER

10) Statement of Statewide Policy Objectives: Rules do not affect units of local government.

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking:

Any interested party may submit written comments or arguments concerning this proposed rule. Written submissions shall be filed with:

Mr. Roger Finnell
Department of Transportation
Division of Aeronautics
One Langhorne Bond Drive/Capital Airport
Springfield, Illinois 62707
(217) 785-1764

Comments received within thirty days of the date of publication of this Illinois Register will be considered. Comments received after that time will be considered, time permitting.

12) Initial Regulatory Flexibility Analysis: Rules do not affect small businesses.

The full text of the Proposed Repealer begins on the next page:

TITLE 92: TRANSPORTATION
CHAPTER I: DEPARTMENT OF TRANSPORTATION
SUBCHAPTER b: AERONAUTICS

PART 50
INGERSOLL AIRPORT ZONING REGULATIONS

Section

AUTHORITY: Implementing and authorized by the Airport Zoning Act (Ill. Rev. Stat. 1981, ch. 15 1/2, par. 48.1 et seq.).

SOURCE: Filed and effective August 21, 1972; codified at 6 Ill. Reg. 15273; repealed at 16 Ill. Reg. _____, effective _____ _____.

Section 50.5 Introduction

a) Zoning provisions regulating and restricting the height of structures and objects of natural growth, and otherwise regulating the use of property in the vicinity of the Ingersoll Airport by creating airport approach zones, transition zones, horizontal zone and conical zones; and establishing the boundaries thereof; providing for changes in the restrictions and boundaries of such surfaces, defining certain terms

used herein; referring to the Ingersoll Airport zoning map (Note: this zoning map can be viewed at the Department of Transportation, Division of Aeronautics, Capital Airport, Springfield, Illinois, 62707. For an example of this information see 92 Ill. Adm. Code 18, Exhibits A, B and C); providing for enforcement; imposing penalties in the interest of public safety and welfare.

b) These zoning regulations are adopted by the Department of Aeronautics, State of Illinois at the request of Canton Park District, a municipal corporation of the State of Illinois, as owner and operator of the Ingersoll Airport, pursuant to the authority conferred by an Act entitled, the Airport Zoning Act (Ill. Rev. Stat. 1981, ch. 110, pars. 48.1-48.37). It is hereby found that an airport hazard endangers the lives and property of users of the Ingersoll Airport and of occupants of land or to property in its vicinity, and also if of the obstruction type, in effect reduces the size of the area available for the landing, taking off and maneuvering of aircraft, thus tending to destroy or impair the utility of the Ingersoll Airport and the public investment therein.

1) Accordingly, it is declared:

A) that the creation or establishment of an airport hazard is a public nuisance and an injury to the region served by the Ingersoll Airport;

B) that it is necessary in the interest of the public health, public safety and general welfare that the creation or establishment of airport hazards be prevented, and

C) that the prevention of these hazards should be accomplished to the extent legally possible by the exercise of the police power without compensation. It is further declared that both the prevention of the creator or establishment of airport hazards and the elimination, removal, alteration, mitigation or marking and lighting of existing airport hazards are public purposes for which the state and its political subdivisions may raise and expend public funds and acquire land or interests in land.

c) It is hereby determined by the Department of Aeronautics, State of Illinois, that the zoning

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regualtions for the Ingersoll Airport be adopted as follows:

Section 50.10 Short Title

These zoning regulations shall be known and may be cited at "Ingersoll Airport Zoning Regulations".

Section 50.20 Definitions

As used in these zoning regulations, unless the context otherwise requires:

"Airport" - means the Ingersoll Airport located near Canton, in the West 1/2 of the Northeast 1/4 and the East 1/2 of the Northwest 1/4 of Section 29; and a part of the South 1/2 of the Southwest 1/4 and part of the Southeast 1/4 of Section 20; Township 7 North, Range 4 East, of the Fourth Principal Meridian, Fulton County, Illinois.

"Airport Elevation" - means the established elevation of the highest point on the useable landing area; the established airport elevation shall be 682 feet above mean sea level.

"Airport Hazard" - means any structure, tree, or use of land or water which obstructs the airspace required for, or is otherwise hazardous to the flight of aircraft in landing or taking off at the airport.

"Airport Reference Point" - means the point established as the approximate geographic center of the airport landing area and so designated as at Latitude 40° 34' 15.0" N and Longitude 90° 04' 30.0" W.

"Alteration" - means any construction which would result in a change in height of lateral dimensions of an existing structure.

"Construction" - means the erection or alteration of any structure either of a permanent or temporary character.

"Department" - means the Department of Aeronautics of the State of Illinois.

"Growth" - means any object of natural growth, including trees, shrubs or foliage.

"Height" - means the overall height of the top of a structure including any appurtenance installed thereon, and for the purpose of determining the height limits in all zones set forth in these regulations and shown on the zoning map, the datum of which shall be mean sea level elevation unless otherwise specified.

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"Instrument Runway" - means a runway equipped or to be equipped with a precision electronic navigation aid or landing aid or other air navigation facilities suitable to permit the landing of aircraft by an instrument approach under res

"Landing Area" - means the area of the airport used for the landing, taking off or taxing of aircraft.

"Non-Corming Use" - means any structure, growth, or use of land which is lawfully in existence at the time these zoning regulations or an amendment thereto becomes effective and does not then meet the requirements of said regulations.

"Non-Instrument Runway" - means a runway other an instrument runway.

"Permit" - means a permit issued by an affected political subdivision where referred to herein.

"Person" - means an individual, firm, partnerhip, corporation, company, association, joint stock association, or body politic, and includes a trustee, receiver, assignee, administrator, executor, guardian, or other representative, and including this State and the Department of Aeronautics.

"Political Subdivision" - means any municipality, city, incorporated town, village, county, township, district, or authority, or any combination of two or more thereof, situated in whole or in part within any of the zones established by Sections 50.30 and 50.50 hereof.

"Runway" - means the paved surface of an airport landing strip.

"Slope Ratio" - means a numerical expression of a stated relationship of height to horizontal distance, e.g. 1 to 100 means one foot vertically for each one hundred feet of horizontal distance.

"State" - means the State of Illinois

"Structure" - means any form of construction or apparatus of a permanent or temporary character, constructed or installed by man, including any implements or material used in the erection, alteration or repair of such structure, including but without limitation, buildings, towers, smokestacks, and overhead transmission lines.

"Variance" - means a grant of relief by the Department from the requirements of these zoning regulations, in accordance with Section 50.10.

Section 50.30 Zones

In order to carry out the provisions of these zoning

regulations, there are created and established certain zones which include all of the land lying within the instrument approach zones, non-instrument approach zones, transition zones, horizontal zone and conical zone. Such areas and zones are shown on the Ingersoll Airport Zoning Map consisting of one (1) sheet, prepared by Casler and Associates, and dated March 31, 1969, (Note: this zoning map can be viewed at the Department of Transportation, 2300 South Dirksen Parkway, Springfield, Illinois, 62764. For an example of this information see 92 Ill. Adm. Code 18, Exhibits A, B and C). The various zones are hereby established and defined as follows:

a) Instrument Approach Zone - an instrument approach zone is hereby established at each end of the instrument runway for instrument landings and take-offs. The instrument approach zone shall have a width of One Thousand (1000) feet at a point Two Hundred (200) feet beyond each end of the runway, widening uniformly thereafter to a width of Sixteen Thousand (16,000) feet at a distance of Fifty Thousand Two Hundred (50,200) feet from beyond each end of the runway, its centerline being the continuation of the centerline of the runway.

b) Non-Instrument Approach Zone - a non-instrument approach zone is established at each end of the non-instrument runway for non-instrument landings andtake-offs. The non-instrument approach zone shall have a width of Five Hundred (500) feet at a point Two Hundred (200) feet from the end of the runways widening thereafter uniformly to a width of Two Thousand Five Hundred (2,500) feet at a distance of Ten Thousand Two Hundred (10,200) feet from the end of the runway, its centerline being the continuation of the centerline of the runway.

c) A Visual Flight Rules (VFR) Approach Zone - A VFR approach zone shall have a width of Two Hundred (200) feet at a distance of One Hundred (100) feet beyond each end of the runway widening thereafter uniformly to a width of 500 feet at a distance of Three Thousand One Hundred (3,100) feet beyond each end of the runway.

d Transition Zones - transition zones are hereby established adjacent to both the instrument and non-instrument runways and approach zones as indicated on the zoning map. Transition zones located normal to and at the elevation of the centerline of the instrument and non-instrument runways, have variable widths as shown on the zoning map. Transition zones extend outward from a line 250 feet normal to and at the elevation of the centerline of the non-instrument runway, for the length of such runway plus 200 feet on each end; and 500 feet normal to and at the elevation of the centerline of the instrument runway, for the length of such runway plus 200 feet on each end, and are parallel and level with such runway centerlines. The transition zones along such runways slope upward and outward one (1) foot vertically for each seven (7) feet horizontally to the point where they intersect the surface of the horizontal zone. Further, transition zones are established adjacent to both the instrument and non-instrument approach zones, having variable widths, as shown on the zoning map. Such transition zones flare symmertrically with either side of the runway approach zones from the base of such zones and slope upward and outward at the rate of one (1) foot vertically for each seven (7) feet horizontally to the points where they intersect the surfaces of the horizontal and conical zones. Additionally, transition zones are established adjacent to each instrument approach zones at right angles to the continuation of the centerline of the runway.

e) Horizontal Zone - a horizontal zone is hereby established as the area within a circle with its center at the Airport Reference Point and having a radius of Seven Thousand (7,000) feet. The horizontal zone does not include the instrument and non-instrument approach zone and the transition zones.

f) Conical Zone - a conical zone is hereby established as the area that commences at the periphery of the horizontal zone and extends outward therefrom a distance of Five Thousand (5000) feet. The conical zone does not include the instrument approach zones and transition zones.

Section 50.40 Height Limitations

Except as otherwise provided in these zoning regulations, no structure or tree shall be erected, altered, allowed to grow, or maintained in any surface created by these zoning regulations to a height in excess of the height limit herein established for such zone. Such height limitations are hereby established for each of the zones in question as follows:

a) Instrument Approach Zone - One (1) foot in height for each Fifty (50) feet in horizontal distance beginning at a point Two Hundred (200) feet from and at the centerline elevation of the end of the instrument runway extending to a distance of Ten Thousand Two

Hundred (10,200) feet from the end of the runway, thence one foot in height for each Forty (40) feet in horizontal distance to a point Fifty Thousand Two Hundred (50,200) feet from the end of the runway.

b) Non-Instrument Approach Zones - One (1) foot in height for each Forty (40) feet horizontal distance beginning at a point Two Hundred (200) feet from and at the centerline elevation of the end of the Non-instrument runway and extending to a point Ten Thousand Two Hundred (10,200) feet from the end of the runway.

c) Visual Flight Rules (VFH) Airport Approach Zones - One (1) foot in height for each Twenty (20) feet in horizontal distance beginning at a point (100) feet from and at the centerline elevation of the end of the runway and extending to a oint 3,100 feet from the end of the runway.

d) Transition Zone - These surfaces extend outward and upward one (1) foot in height for each seven (7) feet in horizontal distance perpendicular to the runway centerline until they meet the horizontal or conical surfaces and beginning at a point 250 feet on either side and normal to and at the elevation of the centerline of non-instrument runways, extending 200 feet beyond each end thereof and 500 feet on either side and normal to and at the elevation of the centerline of the instrument runway, extending 200 feet beyond each end thereof and 500 feet on either side and normal to and at the elevation of the centerline of the instrument runway, extending 200 feet beyond each end thereof; extending upward to a maximum height of 150 feet above the established airport elevation which is 682 feet above mean sea level. In addition to the foregoing, there are established height limits of one (1) foot vertical height for each Seven (7) feet horizontal distance measured from the edges of all approach zones for the entire length of the approach zones and extending upward and outward to the points where they intersect the horizontal and conical surfaces. Further, where the instrument approach surface projects through and beyond the conical zone, a height limit of one (1) foot for each (7) feet of horizontal distance shall be maintained beginning at the edge of the instrument approach zone and extending a distance of 5000 feet from the edge of the instrument approach zone measured normal to the continuation of the centerline of the runway extended.

e) Horizontal Zone - The horizontal zone shall have an

elevation of 150 feet above the established airport elevation (682 feet MSL) or an elevation of 832 feet above mean sea level.

f) Conical Zone - The conical zone is one (1) foot in height for each 20 feet of horizontal distance beginning at the periphery of the horizontal zone extending to a height of 400 feet above the airport elevation.

Section 50.50 Use Restrictions

a) General - Notwithstanding any other provisions of these zoning regulations, no use may be made of land within any zone in such a manner as to create electrical or electronical interference with radio or radar communications between the airport and aircraft; or to the installation and use of flashing or illuminated advertising or business signs, billboards, or any other type of illuminated structure which would be hazardous for flyers because of the difficulty in distinguishing between airport lights and others, or which result in glare in the eyes of flyers using the airport, thereby impairing visibility in the vicinity of the airport or endangering the landing, taking off, or maneuvering of aircraft; or which would emit or discharge smoke that would interfere with the health and safety of flyers and the public in the use of the airport, or which would otherwise be detrimental or injurious to the health, safety and general welfare of the public in the use of the airport.

b) Land Use Restriction Zone - The land use Restriction Zone shall be those areas underneath the approach zones, including the Transitional Zones, at the ends of each runway to a distance of 10,200 feet from the end of the runway. The Canton Park District shall make every effort to discourage further development of residential buildings and places of public assembly involving educational, institutional, amusement and recreational uses. Any repeal or application for an amendment, variation or special use to a zoning ordinance or other ordinance of a political subdivision affecting land use within the land use restriction zone shall require a public hearing and notice to be made to the Canton Park District, the Department, and the Federal Aviation Administration, at least thirty (30) days prior to the public hearing.

Section 50.60 Non-Conforming Uses

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a) Regulations Not Retroactive - These zoning regulations perscribed this zoning regulation shall not be construed to require the removal, lowering, or other changes or alteration of any structure or tree notconforming to the regulations as of the effective date of these zoning regulations or otherwise interfere with the continuance of any non-conforming use. Nothing herein contained shall require any change in the construction, alteration or intended use of any structure, the construction or alteration of which was begun prior to the effective date of these zoning regulations and is diligently prosecuted.

b) Marking and Lighting - Notwithstanding the provisions of Section 50.60 (a), the owner of any existing non-conforming structure is hereby required to permit the trimming of trees or the installation, operation and maintenance on such structures of such markers and lights as shall be deemed necessary by the Department to indicate to flyers in the vicinity of the airport, the presence of such airport hazards, all to be performed at the expense of the Canton Park District.

Section 50.70 Spacing Adjacent Airports, Restricted Landing Areas, Restricted Landing Area-Heliports

No airport or restricted landing area or restricted landing area-heliport shall be established within the zones hereinbefore described.

Section 50.80 Permits

After the effective date of these zoning regulations, the plans and specifications submitted by any person in connection with the application for a building permit must be in compliance with the regulations as herein set forth and with the requirements of the Federal Aviation Regulations Objects Affecting Navigable Airspace (14 CFR 77) issued by the Federal Aviation Administration, and with the Airport Zoning Act of the state of Illinois Revised Statues. Any permit issued in contravention of these zoning regulations shall be void.

Section 50.90 Non-Conforming Structures or Uses Abandoned or Destroyed

Whenever the Department dtermines that a non-conforming structure or use has been abadoned or more than 80 per cent torn down, destroyed, or deteriorated:

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a) No permit shall be granted that will allow such structure or use to exceed the applicable height limit otherwise deviate from these zoning regulations; and

b) Whether application is made for a permit, or not, the Department may, by appropriate action, compel the owner of the non-conforming structure or use, at his own expense, to lower, remove, reconstruct, or equip such structure or use as may be necessary to conform to these zoning regulations. If the owner of the non-conforming structure or use shall neglect or refuse to comply with such order within ten (10) days after notice thereof; the Department may proceed to have such structure or use so lowered, removed, reconstructed or equipped and shall have a lien, on behalf of the State, upon the land whereon it is or was located, in the amount of the cost and expense thereof. Such lien may be enforced by the Department of behalf of the State by suit in equity for the enforcement thereof as in the case of other liens.

Section 50.100 Variances

a) General - Any peron desiring to erect or increase the height of any structure, or permit the growth of any tree, or use his property not in accordance with these zoning regulations, may apply to the Department for a variance from these regulations. Such variances shall be allowed where it is duly found that a literal application or enforcement of these zoning regulations would result in practical difficulty or unnecessary hardship and the relief granted would not be contrary to the public interest but would do substantial justiceand be in accordance with the spirit of these zoning regulations.

b) Marking and Lighting - Any variance granted by the Department may be so conditioned as to require the owner of such structure to permit, at the expense of Canton Park District, the installation, operation and maintenance thereon of such markers and lights as may be required to indicate to flyers the presence of such structure.

Section 50.110 Enforcement

It shall be the duty of the Department to administer and enforce these zoning regulations. Applications for permits or variances, required by these zoning regulations to be submitted

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to the Department, shall be on forms furnished by the Department and shall be promptly considered and granted or denied by the Department.

Section 50.120 Appeal and Judicial Review

Any person aggrieved, or any taxpayer affected, by and decision of the Department may appeal to the Circuit Court of Fulton County, Illinois, in accordance with the provisions of an Act entitled the Administrative Review Law (Ill. Rev. Stat. 1981, ch. 110, pars. 3-101 et seq.).

Section 50.130 Penalties

Each violation of these zoning regulations or of any regulations, order, or ruling promulgated hereunder shall constitute an airport hazard and a misdemeanor, and such hazard shall be removed by proper legal proceedings and such misdemeanor shall be punished by a fine of not more than Two Hundred Dollars ($200.00) and each day a violation continues to exist shall constitute a separate offense. In addition, the Department may institute in the Circuit Court of Fulton County an action to prevent and restrain, correct or abate, any violation of these zoning regulations, or of any regulation, order or ruling made in connection with their administration or enforcement, and the Court shall adjudge such relief by way of injunction (which may be mandatory) or otherwise, as may be proper under all the facts and circumstances of the case, in order fully to effectuate the purposes of these zoning regulations as adopted and orders and rulings made pursuant thereto.

Section 50.140 Conflicting Regulations

Where a conflict exists between any of these zoning regulations and any other regulations or ordinances applicable to the same area, whether the conflict be with respect to the height of structures, or trees, the use of land, or any other matter, the more stringent regulation or ordinance shall govern and prevail

Section 50.150 Severability

If any of the provisions of these zoning regulations or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of these zoning regulations which can be given effect without the invalid provision or application, and to this

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end, the provisions of these zoning regulations are declared to be severable.

Section 50.160 Effective Date

a) Whereas, the immediate application of the provisions of these zoning regulations are necessary for the preservation of the public health, public safety, and general welfare, an emergency is hereby declared to exist, and these zoning regulations shall be in full force and effect from and after its adoption by the Department, concurrence by the Illinois Commerce Commission, and filing with the Secretary of State.
b) Adopted by the Department of Aeronautics on the 4th day of June 1971.
c) Concurred in by the Illinois Commerce Commission by Order dated June 21, 1972 in Docket No. 56630.

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NOTICE OF PROPOSED RULES

1) Heading of Part: Ingersoll Municipal Airport Hazard Zoning

2) Code Citation: 92 Ill. Adm. Code 50

3) Section Numbers: Proposed Action:

50.10	New Section
50.20	New Section
50.30	New Section
50.40	New Section
50.50	New Section
50.60	New Section
50.70	New Section
50.80	New Section
50.90	New Section
50.100	New Section
50.110	New Section
50.120	New Section
50.130	New Section
50.140	New Section
50.EXHIBIT A	New Exhibit

4) Statutory Authority: Ill. Rev. Stat. 1991, ch. 15 1/2, par. 48.17

5) A complete description of the subjects and issues involved:

This Part provides for the establishment of an airport hazard area in the vicinity of the Ingersoll Airport. This Part provides for the safety of the aircraft and persons on the ground by governing surfaces and height limitations in respect to structures erected or altered in the vicinity of the airport.

Elsewhere in this issue of the Illinois Register, the Department is repealing the old Part 50 and replacing it with this new Part.

A complete description of the significant differences between the repealed rules and the new rules follows. These changes have been made to other airport hazard zoning regulations promulgated by the Department at the suggestion of the Joint Committee on Administrative Rules.

In the definition of "Airport Elevation," the elevation has changed from 682'to 684'.

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In the definition of "Airport Reference Point," the point has changed from 40 34'15", 90 04'30" to 40 34'13", 90 04'27".

The following definitions were added to the new Part: "Circling Approach Area," "Departure Area," "Final Approach Segment," "Flight Safety Coordinator," "Initial Approach Segment," "Intermediate Approach Segment," "Minimum Instrument Flight Altitude," "Non-Precision Instrument Runway," "Obstacle Clearance," "Precision Instrument Runway," "Tree," "Utility Runway," "Visibility Minimums," and "Visual Runway."

These definitions were deleted from the new Part: "Growth," "Instrument Runway," and "Non-Instrument Runway."

The definition of "Runway" has changed to include other runway surfaces.

Section 50.30 of the new Part is a combination of the Sections on zones and height limitations in the old Part.

All zones are renamed "surfaces" and are updated to current dimensions.

New provisions have been added concerning the "Circling Approach Surface," the "Terminal Obstacle Clearance Area," and the "Excepted Height Limitations" in Section 50.30.

In Section 50.40 of the new Part, smoke has been added as a use restriction.

Old Section 50.50(b) and Section 50.70 have been deleted from the new Part. These Sections have to do with the land use restriction zone and spacing adjacent airports.

In Section 50.60 of the new Part, standards for appoval of a permit have been set out.

Section 50.90, Notice of Construction or Alteration, is a new Section.

The references to 92 Ill. Adm. Code 18, Exhibits A, B, and C have been removed from the new Part because they are inappropriate.

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6) Will this proposed rulemaking replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed rule contain incorporations by reference? No

9) Are there any other amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: Rules do not affect units of local government.

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking:

Any interested party may submit written comments or arguments concerning this proposed rule. Written submissions shall be filed with:

Mr. Roger Finnell
Department of Transportation
Division of Aeronautics
One Langhorne Bond Drive/Capital Airport
Springfield, Illinois 62707
(217) 785-1764

Comments received within thirty days of the date of publication of this Illinois Register will be considered. Comments received after that time will be considered, time permitting.

12) Initial Regulatory Flexibility Analysis: Rules do not affect small businesses.

The full text of the Proposed Rules begins on the next page:

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NOTICE OF PROPOSED RULE

TITLE 92: TRANSPORTATION
CHAPTER I: DEPARTMENT OF TRANSPORTATION
SUBCHAPTER b: AERONAUTICS

PART 50
INGERSOLL MUNICIPAL AIRPORT
HAZARD ZONING

Section
50.10 Introduction
50.20 Definitions
50.30 Surfaces and Height Limitations
50.40 Use Restrictions
50.50 Non-Conforming Uses
50.60 Permits
50.70 Non-Conforming Structures or Uses or Trees Abandoned or Destroyed
50.80 Variances
50.90 Notice of Construction or Alteration
50.100 Enforcement
50.110 Appeal and Judicial Review
50.120 Penalties
50.130 Conflicting Regulations
50.140 Severability
50.EXHIBIT A Proposed Construction Permit Request

AUTHORITY: Implementing and authorized by Section 17 of the Airport Zoning Act (Ill. Rev. Stat. 1989, ch. 15 1/2, par. 48.17).

SOURCE: Filed and effective August 21, 1972; codified at 6 Ill. Reg. 15273; Part repealed, new Part adopted at 16 Ill. Reg. _____, effective _____.

NOTE: Capitalization denotes statutory language.

Section 50.10 Introduction

a) This Part regulates and restricts the height of structures and trees, and otherwise regulates the use of property in the vicinity of the Ingersoll Airport by creating appropriate surfaces, and establishing the boundaries thereof; providing for changes in the restrictions and boundaries of such surfaces, defining certain terms used herein; referring to the Ingersoll Airport zoning map (Note: This zoning map can be

viewed at the Department of Transportation, Division of Aeronautics, One Langhorne Bond Drive/Capital Airport, Springfield, Illinois 62707-8415.); providing for enforcement; imposing penalties in the interest of public safety and welfare; and providing for notice of construction or alteration.

b) This Part is adopted at the request of the Canton Park District, as owner and operator of Ingersoll Airport, pursuant to the authority conferred by the Airport Zoning Act (Act) (Ill. Rev. Stat. 1989, ch. 15 1/2, pars. 48.1 et seq.). IT IS HEREBY FOUND THAT AN AIRPORT HAZARD ENDANGERS THE LIVES AND PROPERTY OF USERS OF Ingersoll Airport AND OF OCCUPANTS OF LAND or property IN ITS VICINITY, AND ALSO, IF OF THE OBSTRUCTION TYPE, IN EFFECT REDUCES THE SIZE OF THE AREA AVAILABLE FOR THE LANDING, TAKING-OFF AND MANEUVERING OF AIRCRAFT, THUS TENDING TO DESTROY OR IMPAIR THE UTILITY OF Ingersoll Airport AND THE PUBLIC INVESTMENT THEREIN.

1) ACCORDINGLY, IT IS DECLARED:

A) THAT THE CREATION OR ESTABLISHMENT OF AN AIRPORT HAZARD IS A PUBLIC NUISANCE AND AN INJURY TO THE region SERVED BY Ingersoll Airport;

B) THAT IT IS NECESSARY IN THE INTEREST OF THE PUBLIC HEALTH, PUBLIC SAFETY AND GENERAL WELFARE THAT THE CREATION OR ESTABLISHMENT OF AIRPORT HAZARDS BE PREVENTED; AND

C) that the prevention of these hazards SHOULD BE ACCOMPLISHED TO THE EXTENT LEGALLY POSSIBLE, BY THE EXERCISE OF THE POLICE POWER, WITHOUT COMPENSATION.

2) IT IS FURTHER DECLARED THAT BOTH THE PREVENTION OF THE CREATION OR ESTABLISHMENT OF AIRPORT HAZARDS AND THE ELIMINATION, REMOVAL, ALTERATION, MITIGATION, OR MARKING AND/or LIGHTING OF EXISTING AIRPORT HAZARDS ARE PUBLIC PURPOSES FOR WHICH POLITICAL SUBDIVISIONS MAY RAISE AND EXPEND PUBLIC FUNDS AND ACQUIRE LAND or interests in land. (Section 11 of the Act)

Section 50.20 Definitions

As used in this Part, unless the context otherwise requires:

"Airport" - The Ingersoll Airport located near Canton, situated in Section 29, Township 7 North, Range East of the Fourth Principal Meridian, Fulton County, Illinois;

also known as Ingersoll Airport.

"Airport Elevation" - The established elevation of the highest point on the usable landing strip; the established airport elevation shall be 684 feet above mean sea level (AMSL).

"Airport Hazard" - ANY STRUCTURE, TREE, OR USE OF LAND WHICH OBSTRUCTS THE AIRSPACE REQUIRED FOR, OR IS OTHERWISE HAZARDOUS TO THE FLIGHT OF AIRCRAFT IN LANDING OR TAKING-OFF AT THE AIRPORT. (Section 3 of the Act)

"Airport Reference Point" - The point established as the approximate geographic center of the airport landing area and so designated as at Latitude 40° 34' 13.0" N and Longitude 90° 04' 27.0" W.

"Alteration" - Any construction which would result in a change in height or lateral dimensions of an existing structure.

"Approach, Transitional, Horizontal and Conical Surfaces" - These surfaces are defined in Section 50.30.

"Circling Approach Area" - That obstacle clearance area which shall be considered for aircraft maneuvering to land on a runway which is not aligned with the final approach course of the approach procedure.

"Construction" - The erection or alteration of any structure either of a permanent or temporary character.

"Department" - The Department of Transportation, Division of Aeronautics of the State of Illinois.

"Departure Area" - That area which begins at the departure end of the runway and has a beginning width of 1000' (500' from centerline). The area splays 15° on each side of the extended runway centerline for a distance of 2 Nautical Miles (NM). Additionally, it includes a second surface that extends radially from a point on the runway centerline located 2,000' from the start end of the runway and extends the distance necessary to provide a 40:1 obstacle identification surface to reach the minimum altitudes authorized for en route operations.

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"Final Approach Segment" - That area of an approach where the aircraft makes final alignment and descent for landing.

"Flight Safety Coordinator" - An employee of the Department whose duties include, but are not limited to inspection of airports, review of complaints concerning uses of property in the vicinity of airports and inspection of structures, uses and trees in the vicinity of airports to determine if such structures, uses or trees impair the use of the airport by aircraft.

"Height" - The overall height of the top of a structure including any appurtenances installed thereon, for the purpose of determining the height limits in all zones set forth in this Part and shown on the zoning map, the datum of which shall be mean sea level elevation unless otherwise specified.

"Initial Approach Segment" - That area of an instrument approach between a point where aircraft departs the enroute phase of flight and is maneuvering to enter an intermediate segment. Such approach segments may be made along an arc, radial, course, heading, radar vector or a combination thereof.

"Intermediate Approach Segment" - That area of an approach between the initial and final approach segments where the aircraft adjusts configuration, speed and positioning along positive course guidance such as radial or course.

"Landing Area" - The area of the airport used for the landing, taking-off or taxiing of aircraft including the unprepared surfaces adjacent to the existing runways.

"Minimum Instrument Flight Altitude" - An altitude established for instrument flight between radio fixes that provides obstacle clearance over the terrain and man-made objects, and is adequate for navigational performance and communications requirements.

"Non-Conforming Use" - Any structure, tree, or use of land which is lawfully in existence at the time this Part or an amendment thereto becomes effective and does not then meet the requirements of this Part.

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"Non-Precision Instrument Runway" - A runway having an existing instrument approach utilizing air navigation facilities with only horizontal guidance, or area type navigation equipment, for which a straight-in, non-precision instrument approach procedure has been approved by the Federal Aviation Administration [FAA], or planned, and for which no precision approach facilities are planned, or indicated on an FAA planning document or military service, military airport planning document.

"Obstacle Clearance" - The vertical distance between the lowest authorized flight altitudes and a prescribed surface within a specified area.

"Permit" - A permit issued by the Department of Transportation, Division of Aeronautics, pursuant to Section 50.60 of this Part.

"Person" - An INDIVIDUAL, FIRM, partnership, CORPORATION, COMPANY, ASSOCIATION, JOINT STOCK ASSOCIATION, OR BODY POLITIC, and includes a TRUSTEE, RECEIVER, ASSIGNEE, administrator, executor, guardian, OR OTHER REPRESENTATIVE, AND INCLUDING THIS STATE and the Division of Aeronautics. (Section 7 of the Act)

"Political Subdivision" - ANY MUNICIPALITY, CITY, INCORPORATED TOWN, VILLAGE, COUNTY, TOWNSHIP, DISTRICT, OR AUTHORITY, OR ANY COMBINATION OF TWO OR MORE THEREOF, situated in whole or in part within any of the surfaces established by Section 50.30. (Section 6 of the Act)

"Precision Instrument Runway" - A precision instrument runway is one which uses an instrument landing system (ILS) or precision approach radar (PAR). A planned precision instrument runway is one for which a precision approach system is indicated on a Department approved Airport Layout Plan, which is on file at the Department of Transportation, Division of Aeronautics, Bureau of Engineering, One Langhorne Bond Drive/Capital Airport, Springfield, Illinois 62707-8415.

"Runway" - An area of the airport designated for the landing or taking off of aircraft and consisting of turf or concrete, asphalt, oil and chip or other composite material that forms an all weather surface other than turf.

"Slope Ratio" - A numerical expression of a stated relationship of height to horizontal distance, e.g. 100 to 1 means one hundred feet of horizontal distance for each one foot vertically.

"State" - THE STATE OF ILLINOIS. (Section 8 of the Act)

"Structure" - Any form of construction or apparatus of a permanent or temporary character, constructed or installed by man, including any implements or material used in the erection, alteration or repair of such structure, including but without limitation, buildings, towers, smokestacks, and overhead transmission lines.

"Terminal Obstacle Clearance Area" - That area near an airport that contains the initial, intermediate and final approach segments, circling and departure areas which are a part of an instrument approach procedure.

"Tree" - Any object of natural growth.

"Utility Runway" - A runway that is constructed for and intended to be used for propeller driven aircraft of 12,500 pounds maximum gross weight or less.

"Variance" - A grant of relief by the Department from the requirements of this Part, in accordance with Section 50.80.

"Visibility Minimums" - The lowest forward horizontal distance from the cockpit of an aircraft in flight at which prominent unlighted objects may be seen and identified by day and prominent lighted objects may be seen and identified by night.

"Visual Runway" - A visual runway is a runway intended solely for the operation of aircraft using visual approach procedures with no straight-in instrument approach procedure and no instrument designation indicated on a Department approved Airport Layout Plan, which is on file at the Department of Transportation, Division of Aeronautics, Bureau of Engineering, One Langhorne Bond Drive/Capital Airport, Springfield, Illinois 62707-8415.

Section 50.30 Surfaces and Height Limitations

a) Establishment and Creation
   1) The following airport imaginary surfaces are established with relation to the airport and to each runway. The size of each such imaginary surface is based on the category of each runway according to the type of approach available or planned for that runway. The slope and dimensions of the approach surface applied to each end of a runway are determined by the most precise approach existing or planned for that runway end.
   2) Such airport imaginary surfaces are hereby created and established in order to carry out the provisions of this Part. Such surfaces shall include all of the land lying within the horizontal surface, conical surface, primary surface, approach surface to include non-precision instrument approach, precision instrument approach and visual approach, transitional surface and circling approach surface. These surfaces are shown on the Airport Zoning Map (Note: This zoning map can be viewed at the Department of Transportation, Division of Aeronautics, One Langhorne Bond Drive/Capital Airport, Springfield, Illinois 62707-8415.) for Ingersoll Airport prepared by Casler, Houser & Hutchison, Inc., Jacksonville, Ill. An area located in more than one of the following surfaces is considered to be only in the surface with the more restrictive height limitation.
   3) Except as otherwise provided in this Part, no structure or tree shall be erected, altered, allowed to grow, or maintained in any surface created by this Part to a height in excess of the height limit herein established for such surfaces.
   4) The various surfaces are hereby established, and height limitations are hereby established for each of the surfaces, as follows:

b) Horizontal Surface
   1) A horizontal plane 150 feet above the established airport elevation of 684 feet Above Mean Sea Level (AMSL), the perimeter of which is constructed by swinging arcs of specified radii from the center of each end of the primary surface of each runway and connecting the adjacent arcs by lines tangent to those arcs. The radius of each arc is:
      A) 5,000 feet for all runways designated as utility or visual;
      B) 10,000 feet for all other runways.

2) The radius of the arc specified for each end of a runway will have the same arithmetical value. That value will be the highest determined for either end of the runway. When a 5,000 foot arc is encompassed by tangents connecting two adjacent 10,000 foot arcs, the 5,000 foot arc shall be disregarded on the construction of the perimeter of the horizontal surface. The horizontal surface does not include the approach and transitional surfaces.

c) Conical Surface
1) A surface extending outward and upward from the periphery of the horizontal surface, at 150 feet above the airport elevation, at a slope of 20 feet horizontally for each foot vertically for a horizontal distance of 4,000 feet.
2) The conical surface does not include the approach surfaces to the precision instrument runways and the transitional surfaces.

d) Primary Surface
1) A surface longitudinally centered on a runway. When the runway has a specially prepared hard surface, the primary surface extends 200 feet beyond each end of that runway; but when the runway has no specially prepared hard surface, or planned hard surface, the primary surface ends at each end of that runway. The elevation of any point on the primary surface is the same as the elevation of the nearest point on the runway centerline. The width of a primary surface is:
A) 250 feet for utility runways having only visual approaches;
B) 500 feet for utility runways having non-precision instrument approaches;
C) For other than utility runways, the width is:
i) 500 feet for visual runways having only visual approaches;
ii) 500 feet for non-precision instrument runways having visibility minimums greater than three-fourths statute mile;
iii) 1,000 feet for a non-precision instrument runway having a non-precision instrument approach with visibility minimums as low as three-fourths statute mile, and for precision instrument runways.
2) The width of the primary surface of a runway will be the width prescribed in this Section for the most precise approach existing or planned for either end of that runway.

e) Approach Surface - A surface longitudinally centered on the extended runway centerline and extending outward and upward from each end of the primary surface. An approach surface is applied to each end of each runway based upon the type of approach available or planned for that runway end.
1) The inner edge of the approach surface is the same width as the primary surface and it expands uniformly to a width of:
A) 1,250 feet for that end of a utility runway with only visual approaches;
B) 1,500 feet for that end of a runway other than a utility runway with only visual approaches;
C) 2,000 feet for that end of a utility runway with a non-precision instrument approach;
D) 3,500 feet for that end of a non-precision instrument runway other than utility, having visibility minimums greater than three-fourths statute mile;
E) 4,000 feet for that end of a non-precision instrument runway, other than utility, having a non-precision instrument approach with visibility minimums as low as three-fourths statute mile; and
F) 16,000 feet for precision instrument runways.
2) The approach surface extends for a horizontal distance of:
A) 5,000 feet at a slope of 20 feet horizontally for each foot vertically for all utility and visual runways;
B) 10,000 feet at a slope of 34 feet horizontally for each foot vertically for all non-precision instrument runways other than utility; and
C) 10,000 feet at a slope of 50 feet horizontally for each foot vertically with an additional 40,000 feet at a slope of 40 feet horizontally for each foot vertically for all precision instrument runways.
3) The outer width of an approach surface to an end of a runway will be that width prescribed in this subsection for the most precise approach existing or planned for that runway end.

f) Transitional Surface - These surfaces extend outward and upward at right (90^{o}) angles to the runway

centerline and the runway centerline extended at a slope of 7 feet horizontally for each foot vertically beginning at the sides of and at the same elevation of the primary surface and the approach surfaces extending to a height of 150 feet above the airport elevation which is 684 feet AMSL. Transitional surfaces for those portions of the precision approach surface which project through and beyond the limits of the conical surface, extend a distance of 5,000 feet measured horizontally from the edge of the approach surface and at right (90°) angles to the runway centerline.

g) Circling Approach Surface - This is a surface 200 feet above ground level (AGL) or above the established airport elevation, whichever is greater, within three (3) nautical miles of the established reference point of Ingersoll Airport and this surface increases in height in the proportion of 100 feet for each additional nautical mile of distance from the airport reference point up to a maximum of 500 feet.

h) A height within a terminal obstacle clearance area, including an initial approach segment, a departure area, and a circling approach area, which would result in the vertical distance between any point on the object and an established minimum instrument flight altitude within that area or segment to be less than the required obstacle clearance.

i) Excepted Height Limitations - Nothing in this Part shall be construed as prohibiting the growth, construction or maintenance of any tree or structure to a height up to 50 feet above the ground.

Section 50.40 Use Restrictions

Notwithstanding any other provisions of this Part, no use may be made of land or water within any surface established by this Part as follows:

a) Electrical or Electronic Interference
   1) In such a manner as to create electrical or electronic interference with navigational signals or radio or radar communication between the airport and aircraft.
   2) If a complaint of such interference is received by the Department, a Flight Safety Coordinator shall determine if a hazard exists by observing all relevant factors including the type of aircraft using the airport, the traffic patterns at the airport, the time of day and frequency of the interference.

b) Flashing or Illuminated Structures
   1) The installation and use of flashing or illuminated advertising or business signs, billboards, or any other type of illuminated structure which would be hazardous for pilots.
   2) In determining whether such a hazard exists, a Flight Safety Coordinator shall consider factors which include, but are not limited to, assessing the difficulty pilots have in distinguishing between airport lights and others, or which result in glare in the eyes of pilots using the airport, thereby impairing visibility in the vicinity of the airport or endangering the landing, taking off or maneuvering of aircraft, the proximity of the illuminated structure to the airport, and the traffic patterns at the airport.

c) Smoke
   1) A use which would emit or discharge smoke that would interfere with the health and safety of pilots and the public in the use of the airport, or which would otherwise be detrimental or injurious to the health, safety and general welfare of the public in the use of the airport.
   2) In determining if such an emission or discharge of smoke would interfere with the health and safety of pilots and the public, a Flight Safety Coordinator shall consider all relevant factors which include, but are not limited to, the density of the smoke, frequency of the emission or discharge, source of the smoke, general weather patterns in the vicinity, time of day, and volume and type of aircraft which use the airport.

Section 50.50 Non-Conforming Uses

a) Regulations Not Retroactive - Those surface regulations prescribed by this Part shall not be construed to require the removal, lowering or other changes or alteration of any structure or tree not conforming to the regulations as of the effective date of this Part or otherwise interfere with the continuance of any non-conforming use. Nothing contained in this Part shall require any change in the construction, alteration, or intended use of any structure, the construction or alteration of which was begun prior to the effective date of this Part, and is diligently prosecuted.

b) Marking and Lighting

1) Notwithstanding the provisions of subsection (a) of this Section, the owner of any existing non-conforming structure is required to permit the installation, operation and maintenance of such markers and lights as shall be deemed necessary by the Department to indicate to operators of aircraft in the vicinity of the airport, the presence of such airport hazards, all to be performed at the expense of the Canton Park District.
2) In determining the necessity for such markers and lights, the Department shall consider all relevant conditions, including but not limited to, the traffic patterns, volume and type of aircraft at the airport, the general weather patterns in the vicinity, the topography of the airport and the surrounding area, and the height of the structure and its proximity to the approach and transition slopes of the existing runways.

Section 50.60 Permits

a) Future Uses - Except as specifically provided in subsections (a) (1), (2), and (3) of this Section, no material change shall be made in the use of land and no structure or tree shall be erected, altered, planted, or otherwise established in any surface created unless a permit shall have been applied for and granted by the Department. Each application for a permit shall indicate the purpose for which the permit is desired, with sufficient particularity to permit it to be determined whether the resulting use, structure or tree would conform to the regulations prescribed in this Part. If such determination is in the affirmative, the permit shall be granted.
   1) In the area lying within the limits of the horizontal surface and the conical surface, but which is not in violation of height restrictions of primary, transitional and approach surfaces as set forth in this Part, no permit shall be required for any tree or structure less than 75 feet of vertical height above the ground or in any approach and transitional surfaces beyond a horizontal distance of 4,200 feet from each end of the runway, except when, because of terrain, land contour or topographic features, such tree or structure would extend above the height limits prescribed for such surface.

   2) In the areas lying within the limits of visual, precision instrument and non-precision instrument approach surfaces, no permit shall be required for any tree or structure less than 75 feet of vertical height above the ground, except when such tree or structure would extend above the height limit prescribed for such visual, precision instrument or non-precision instrument approach surfaces.
   3) In the areas lying within the limits of the transitional surface beyond the perimeter of the horizontal surface, no permit shall be required for any tree or structure less than 75 feet of vertical height above the ground except when such tree or structure, because of terrain, land contour or topographic features would extend above the height limit prescribed for such transitional surface.

b) Nothing contained in any of the foregoing exceptions shall be construed as permitting or intending to permit any construction, alteration or growth of any structure or tree in excess of any of the height limits prescribed by this Part.

Section 50.70 Non-Conforming Structures or Uses or Trees Abandoned or Destroyed

Whenever the Department following a Flight Safety Coordinator's personal inspection, observation and estimation, DETERMINES THAT A NON-CONFORMING STRUCTURE or use OR TREE HAS BEEN ABANDONED OR MORE THAN 80 PER CENT demolished, DESTROYED, physically DETERIORATED, OR DECAYED:

a) NO PERMIT SHALL BE GRANTED by the Department THAT WOULD ALLOW SUCH STRUCTURE or use OR TREE TO EXCEED THE APPLICABLE HEIGHT LIMIT OR OTHERWISE DEVIATE FROM these ZONING REGULATIONS; AND
b) WHETHER APPLICATION IS MADE FOR A PERMIT, OR NOT, THE DEPARTMENT MAY issue an order pursuant to subsection (c) of this Section, in cases where the remaining structure or use OR TREE constitutes a violation of this Part, compelling THE OWNER OF THE NON - CONFORMING STRUCTURE or use OR TREE, AT HIS OWN EXPENSE, TO LOWER, REMOVE, RECONSTRUCT, OR EQUIP SUCH structure or use OR TREE AS MAY BE NECESSARY TO CONFORM TO these zoning REGULATIONS. IF THE OWNER OF THE NON-CONFORMING STRUCTURE or use OR TREE SHALL NEGLECT OR REFUSE TO COMPLY WITH SUCH ORDER within ten DAYS AFTER NOTICE THEREOF, THE DEPARTMENT MAY PROCEED TO HAVE such

structure or use OR TREE SO LOWERED, REMOVED, RECONSTRUCTED OR EQUIPPED AND SHALL HAVE A LIEN, ON BEHALF OF THE STATE, UPON THE LAND WHEREON IT IS OR WAS LOCATED, IN THE AMOUNT OF THE COST AND EXPENSE THEREOF. SUCH LIEN MAY BE ENFORCED BY THE DEPARTMENT ON BEHALF OF THE STATE BY suit in equity FOR THE ENFORCEMENT THEREOF AS IN THE CASE OF OTHER LIENS. (Section 23 of the Act)

c) The Department shall issue an order if it is determined that the non-conforming structure or use or tree interferes with traffic patterns at the airport. In making such a determination the Department shall consider factors which include, but are not limited to, the type of aircraft using the airport, and whether or not the airport has precision instrument or instrument runways.

Section 50.80 Variances

a) General - ANY PERSON wishing to erect or increase the height of ANY STRUCTURE, OR PERMIT any GROWTH, OR USE HIS PROPERTY not in accordance with these ZONING REGULATIONS, MAY APPLY TO THE DEPARTMENT FOR A VARIANCE FROM these ZONING REGULATIONS. SUCH VARIANCES SHALL BE ALLOWED WHERE it is found that A LITERAL APPLICATION OR ENFORCEMENT OF these ZONING REGULATIONS WOULD RESULT IN PRACTICAL DIFFICULTY OR UNNECESSARY HARDSHIP AND THE RELIEF GRANTED WOULD NOT BE CONTRARY TO THE PUBLIC INTEREST BUT WOULD DO SUBSTANTIAL JUSTICE AND BE IN ACCORDANCE WITH THE SPIRIT OF these ZONING REGULATIONS. (Section 24 of the Act)

b) Marking and Lighting - Any Variance granted by the Department may be so conditioned as to require the owner of such structure or tree to permit, at the expense of the owner, the installation, operation and maintenance of such markers and lights as may be required to indicate to pilots the presence of such structure or tree.

c) In making the determination to allow variances the Department will consider, but is not limited to considering, the proximity of the hazard to the normal flight path or traffic patterns at the airport, the proximity of other non-conforming uses, structures or trees which would impair the use of the airport, the height of the object, the volume of air traffic at the airport, the type of aircraft using the airport, the type of navigational aids used at the airport, the length and width of existing runways, and plans for future expansion of the airport.

Section 50.90 Notice of Construction or Alteration

a) Construction or Alteration Requiring Notice - The Department shall be notified by each person (sponsor) who proposes any of the following construction or alterations with respect to the surfaces and height limitations established by Section 50.30 with respect to Ingersoll Airport:

1) Any construction or alteration of more than 200 feet in height above the ground level at its site.

2) Any construction or alteration of greater height than an imaginary surface extending outward and upward at one of the following slopes:

A) 100 to 1 for a horizontal distance of 20,000 feet from the nearest point of the nearest runway of the airport, with at least one runway more than 3200 feet in actual length.

B) 50 to 1 for a horizontal distance of 10,000 feet from the nearest point of the nearest runway of the airport, with the longest runway not more than 3200 feet in actual length.

3) Any highway, railroad, or other traverse way for mobile objects, of a height which, if adjusted upward 17 feet for an Interstate Highway that is part of the National System of Military and Interstate Highways where overcrossings are designed for a minimum of 17 feet vertical distance; 15 feet for any other public roadway; 10 feet or the height of the highest mobile object that would normally traverse the road, whichever is greater, for a private road; 23 feet for a railroad; and for a waterway or any other traverse way not previously mentioned, an amount equal to the highest mobile object that would normally traverse it, would exceed a standard of subsection (a)(1) or (a)(2) of this Section.

4) Any construction or alteration that would exceed a standard of the Act or this Part.

b) Construction or Alteration Not Requiring Notice - No person is required to notify the Department for any of the following construction or alterations with respect to Ingersoll Airport:

1) Any antenna structure of 20 feet or less in height except one that would increase the height of another antenna structure.

2) Any air navigation facility, airport visual

approach or landing aid, aircraft arresting device, or meteorological device less than 50 feet in height.

3) Any object that would be shielded by permanent and substantial existing structures of equal or greater height or by natural terrain or topographic features of equal or greater height, and would be located in the congested area of a city, town, or settlement where it is evident beyond all reasonable doubt that the structure so shielded will not obstruct or interfere with aircraft using the airport, or cause any additional adverse effect on airport operations by considering the height and location of the existing uses and structures.

c) Form and Time of Notice

1) Each person who is required to notify the Department under subsection (a) shall forward one executed form set (in four copies) of the Department's Form No. DA-39 (for an example, see Exhibit A of this Part) to the Division of Aeronautics, One Langhorne Bond Drive/Capital Airport, Springfield, Illinois 62707. Copies of this form may be obtained from the Department.

2) Such notice must be submitted at least 30 days before the date the proposed construction or alteration is to begin.

3) In the case of an emergency involving essential public services, public health, or public safety, that requires immediate construction or alteration, the 30-day requirement in subsection (c)(2) of this Section does not apply and the notice may be sent by telephone, telegraph, or other expeditious means, with an executed Department Form No. DA-39 submitted within five days. For example, an emergency could include breaks in sewer lines, gas mains or power lines.

d) Acknowledgment of Notice

1) The Department will acknowledge in writing the receipt of such notice submitted under subsection (a) of this Section within 30 days of receipt of such notice.

2) The acknowledgment will state that a study of the proposed construction or alteration has resulted in a determination that the construction or alteration:

A) Would under federal rules require lighting or marking standards as prescribed in Advisory Circular, Department of Transportation, Federal Aviation Administration (FAA), Subject: Obstruction, Marking and Lighting, AC No: 70/7460-1, as provided in 14 CFR 77.11 (b)(3), January 1, 1990, not including any later amendment or editions, and information on how the structure should be marked and lighted in accordance with such FAA standards; and/or

B) Would not exceed any standard of the Act or this Part; or

C) Would exceed a standard of the Act, Aviation Safety Rules (92 Ill. Adm. Code 14), or this Part; or

D) Would require supplemental information from the sponsor in order for a determination to be made by the Department.

Section 50.100 Enforcement

It shall be the duty of the Department to administer and enforce this Part. Applications for permits or variances, required by this Part to be submitted to the Department, shall be on forms furnished by the Department and shall be promptly considered and granted or denied.

Section 50.110 Appeal and Judicial Review

a) APPEAL - ANY PERSON AGGRIEVED BY ANY DECISION OF THE DEPARTMENT MADE IN ADMINISTRATION OF THIS PART MAY APPLY TO THE DEPARTMENT TO REVERSE, WHOLLY OR PARTLY, OR MODIFY, OR OTHERWISE CHANGE, ABROGATE OR RESCIND ANY SUCH DECISION. THE PROCEDURE PRESCRIBED BY THE ACT FOR PROCEEDINGS BEFORE BOARD OF APPEAL SHALL GOVERN SUCH APPLICATION TO THE DEPARTMENT. (Section 29 of the Act)

b) Judicial Review - Any person aggrieved, or any taxpayer affected by any decision of the Department may appeal to the Circuit Court of Fulton County, Illinois, or Circuit Court of any county in which the airport hazard is wholly or partly located, in accordance with the provisions of an Act entitled The Administrative Review Law (Ill. Rev. Stat. 1989, ch. 110, pars. 3-101 et seq.).

Section 50.120 Penalties

Each violation of this Part or of ANY REGULATIONS, ORDERS, OR RULINGS PROMULGATED hereunder shall constitute an airport hazard

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED RULE

and a PETTY OFFENSE, and such hazard shall be removed by proper legal proceedings and EACH DAY A VIOLATION CONTINUES TO EXIST SHALL CONSTITUTE A SEPARATE OFFENSE. IN ADDITION, THE DEPARTMENT MAY INSTITUTE IN THE Circuit Court of Fulton County, Illinois, or CIRCUIT COURT OF ANY COUNTY IN WHICH THE AIRPORT HAZARD is wholly or partly LOCATED, AN ACTION TO PREVENT and RESTRAIN, CORRECT OR ABATE, ANY VIOLATION OF these ZONING REGULATIONS, OR OF ANY regulation, ORDER OR RULING MADE IN CONNECTION WITH THEIR ADMINISTRATION OR ENFORCEMENT, AND THE COURT SHALL ADJUDGE SUCH RELIEF BY WAY OF INJUNCTION (WHICH MAY BE MANDATORY) OR OTHERWISE, AS MAY BE PROPER UNDER ALL THE FACTS AND CIRCUMSTANCES OF THE CASE, IN ORDER FULLY TO EFFECTUATE THE PURPOSES OF these zoning REGULATIONS as ADOPTED AND ORDERS AND RULINGS MADE PURSUANT THERETO. (Section 34 of the Act)

Section 50.130 Conflicting Regulations

Where a conflict exists between this Part and any other regulations or ordinances applicable to the same area, whether the conflict be with respect to the height of structures, or trees, the use of land, or any other matter, the more stringent regulation or ordinance shall govern and prevail.

Section 50.140 Severability

If any of the provisions of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Part which can be given effect without the invalid provision or application, and to this end, the provisions of this Part are declared to be severable.

DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED RULES

Section 50.Exhibit A **Proposed Construction Permit Request**

ILLINOIS DEPARTMENT OF TRANSPORTATION
Division of Aeronautics

Name of Individual or Company
Making Request_____
Address_____
Street City Zip Phone

Nature and Description of Proposed Structure:

☐ New Construction
☐ Alteration

Nearest Town:

Location from Nearest Town

Direction Distance

Nearest Airport:

From Nearest Point to a Runway

Direction Distance

Latitude Longitude

o ' " ' "

Proposed Heights and Elevations

Site Elevation (Mean Sea Level)		Feet
Highest Point of Structure Above Ground		Feet
Overall Height above Mean Sea Level		Feet
Estimated Construction Starting Date		
Estimated Construction Completion Date		
Type of Structure:	Permanent	Temporary
Will Structure be Obstruction Lighted:	Yes	No
Will Structure be Obstruction Marked:	Yes	No

Remarks:

Date: Title or Position: Signature

The Illinois Department of Transportation is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Section 1 of the Airport Zoning Act (Ill.Rev.Stat. 1991, ch. 15 1/2, par. 48.1). Disclosure of this information is REQUIRED. Failure to provide any information will result in denial of the construction permit. This form has been approved by the Forms Management Center.
DA-39 (Rev. 1-87) IL 494-0765

DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

NOTICE OF ADOPTED REPEALER

1) The Heading of the Part: Employment and Training Assistance for Dislocated Workers

2) Code Citation: 56 Ill. Adm. Code 2620

3)

Section Numbers:	Adopted Action:
2620.10	Repeal
2620.20	Repeal
2620.30	Repeal
2620.40	Repeal
2620.50	Repeal
2620.60	Repeal
2620.70	Repeal
2620.80	Repeal
2620.90	Repeal
2620.100	Repeal

4) Statutory Authority: Implementing Section 46.41 of the Civil Administrative Code of Illinois (Ill. Rev. Stat. 1989, ch. 127, par. 46.41) and Sections 301 and 303, 311 through 317, and 321 through 324 of the Job Training Partnership Act (97-300, effective October 13, 1982 (29 U.S.C. 1501), as amended by P.L. 97-404, effective December 31, 1982 (42 U.S.C. 602), P.L. 99-496, effective October 16, 1986 (29 U.S.C. 1501); P.L. 99-570, effective October 27, 1986 (21 U.S.C. 801); and P.L. 100-418, effective August 23, 1988 (20 U.S.C. 5001) and authorized by Section 46.40(b) of the Civil Administrative Code of Illinois (Ill. Rev. Stat. 1989, ch. 127, par. 46.40(b)).

5) Effective Date of Repealer: April 1, 1992

6) Does this rulemaking contain an automatic repeal date? No.

7) Does this repealer contain incorporations by reference? Yes.

8) Date Filed in Agency's Principal Office: March 31, 1992.

9) Notice of Proposal Published in Illinois Register: September 6, 1991 - 15 Ill. Reg. 12964.

10) Has JCAR issued a Statement of Objections to this repealer? No.

11) Differences between proposal and final version: None.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? No changes were requested by JCAR.

13) Will this repealer replace an emergency repealer currently in effect? No.

DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

NOTICE OF ADOPTED REPEALER

14) Are there any amendments pending on this Part? No.

15) Summary and Purpose of Repealer: On August 23, 1988, Title VI, Subtitle D, the Economic Dislocation and Worker Adjustment Assistance Act (EDWAA) was enacted. Existing provisions of Title III of the Job Training Partnership Act were replaced by EDWAA and State rules (56 Ill. Adm. Code 2625) were promulgated by the department to implement the new program. Part 2620 was not repealed at that time because carry-over funds for Title III were still subject to its provisions. Since all carry-over funds have now been expended, the department is repealing this Part.

6) Information and questions regarding this adopted repealer shall be directed to:

Mr. Norman Sims, Deputy Director
Department of Commerce and Community Affairs
Bureau of Policy Development, Planning & Research
620 East Adams Street, 3rd floor
Springfield, Illinois 62701
(217) 524-4845

ILLINOIS COMMERCE COMMISSION

NOTICE OF ADOPTED AMENDMENT

1) The Heading of the Part: Cellular Radio Exclusion

2) Code Citation: 83 Ill. Adm. Code 760

3) Section Numbers: Adopted Action:

760.20 Amendment

4) Statutory Authority: Implementing Section 13-203 of the Universal Telephone Service Protection Law of 1985 (Ill. Rev. Stat. 1989, ch. 111 2/3, par. 13-203) and authorized by Section 10-101 of the Public Utilities Act (Ill. Rev. Stat. 1989, ch. 111 2/3, par. 10.101).

5) Effective Date of Amendment: April 15, 1992

6) Does this rulemaking contain an automatic repeal date? No.

7) Does this amendment contain incorporations by reference? No.

8) Date Filed in Agency's Principal Office: March 31, 1992

9) Notice of Proposal Published in Illinois Register:

October 11, 1991, at 15 Ill. Reg. 14340.
November 15, 1991, at 15 Ill. Reg. 16535

This Notice of Adopted Amendment combines both of the proposed amendments into one adoption. Each of the proposed amendments added different counties to Section 760.20. This Notice combines all the counties for purposes of adopting the amendment.

10) Has JCAR issued a Statement of Objections to this amendment? No.

11) Difference(s) between proposal and final version: None, other than the combination of all counties into one Notice.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? None requested.

13) Will this amendment replace an emergency amendment currently in effect? No.

ILLINOIS COMMERCE COMMISSION

NOTICE OF ADOPTED AMENDMENT

14) Are there any amendments pending on this Part? No.

15) Summary and Purpose of Amendment: This amendment will increase the number of counties in which cellular radio service is excluded from the tariff provisions listed in Section 760.20.

16) Information and questions regarding this adopted amendment shall be directed to:

Conrad Rubinkowski
Illinois Commerce Commission
527 East Capitol Avenue
P.O. Box 19280
Springfield, IL 62794-9280
(217)785-8439

The full text of the Adopted Amendment begins on the next page:

ILLINOIS COMMERCE COMMISSION

NOTICE OF ADOPTED AMENDMENT

TITLE 83: PUBLIC UTILITIES
CHAPTER I: ILLINOIS COMMERCE COMMISSION
SUBCHAPTER f: TELEPHONE UTILITIES

PART 760
CELLULAR RADIO EXCLUSION

Section
760.10 Chicago Metropolitan Area Exclusion
760.20 Downstate Area Exclusions

AUTHORITY: Implementing Section 13-203 of the Universal Telephone Service Protection Law of 1985 (Ill. Rev. Stat. 1989, ch. 111 2/3, par. 13-203) and authorized by Section 10-101 of the Public Utilities Act (Ill. Rev. Stat. 1989, ch. 111 2/3, par. 10-101).

SOURCE: Adopted at 11 Ill. Reg. 11730, effective July 1, 1987; amended at 14 Ill. Reg. 3037, effective February 15, 1990; amended at 14 Ill. Reg. 18756, effective November 15, 1990; amended at Ill. Reg. 6177, effective April 15, 1992.

Section 760.20 Downstate Area Exclusions

Cellular radio service provided by facilities in Bond, Boone, Champaign, Christian, Clinton, DeWitt, Effingham, Fayette, Grundy, Kankakee, Kendall, Logan, Macon, Madison, Marion, Mason, McLean, Menard, Monroe, Montgomery, Moultrie, Peoria, Piatt, Sangamon, St. Clair, Shelby, Tazewell, Winnebago, and Woodford Counties is excluded from the applicable tariff provisions contained in Sections 13-501, 13-502, 13-503, 13-504, 13-505, 13-506, and 13-509 of the Universal Telephone Service Protection Law of 1985 (Ill. Rev. Stat. 1989, ch. 111 2/3, pars. 13-501, 13-502, 13-503, 13-504, 13-505, 13-506, and 13-509).

(Source: Amended at Ill. Reg. 6177, effective April 15, 1992)

ILLINOIS COMMERCE COMMISSION

NOTICE OF ADOPTED AMENDMENT

1) The Heading of the Part: Construction of Electric Power and Communication Lines

2) Code Citation: 83 Ill. Adm. Code 305

3) Section Numbers: Adopted Action:

305.20 Amendment

4) Statutory Authority: Implementing Section 8-505 and authorized by Section 10-101 of the Public Utilities Act (Ill. Rev. Stat. 1989, ch. 111 2/3, pars. 8-505 and 10-101).

5) Effective Date of Amendment: April 15, 1992

6) Does this rulemaking contain an automatic repeal date? No.

7) Does this amendment contain incorporations by reference? Yes, JCAR approval form not necessary.

8) Date Filed in Agency's Principal Office: March 31, 1992

9) Notice of Proposal Published in Illinois Register:

November 15, 1991, at 15 Ill. Reg. 16538.

10) Has JCAR issued a Statement of Objections to this amendment? No.

11) Difference(s) between proposal and final version:

Table of Contents changed to "305.Table A".

Authority Note updated.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? None requested.

13) Will this amendment replace an emergency amendment currently in effect? No.

14) Are there any amendments pending on this Part? No.

ILLINOIS COMMERCE COMMISSION

NOTICE OF ADOPTED AMENDMENT

15) Summary and Purpose of amendment: This amendment will update the incorporation by reference of the National Electric Safety Code and also updates terminology to refer to telecommunications carriers. It also deletes the reference to "railroad public utilities."

16) Information and questions regarding this adopted amendment shall be directed to:

Conrad Rubinkowski
Illinois Commerce Commission
527 East Capitol Avenue
P.O. Box 19280
Springfield, IL 62794-9280
(217)785-8439

The full text of the Adopted Amendment begins on the next page:

ILLINOIS COMMERCE COMMISSION

NOTICE OF ADOPTED AMENDMENT

TITLE 83: PUBLIC UTILITIES
CHAPTER I: ILLINOIS COMMERCE COMMISSION
SUBCHAPTER b: PROVISIONS APPLICABLE TO MORE THAN ONE KIND OF UTILITY

PART 305
CONSTRUCTION OF ELECTRIC POWER AND COMMUNICATION LINES
~~(GENERAL ORDER 160)~~

Section
305.10 Policy
305.20 Scope and Incorporation by Reference of Portions of the National Electric Safety Code (NESC)
305.30 General Rules
305.40 Application
305.50 Certificates of Public Convenience and Necessity
305.60 Notification Procedure for Applications
305.70 Advance Notice and Cooperation
305.80 Interchange Data
305.90 Coordinated Locations of Lines
305.100 Overbuilding or Underbuilding
305.110 Exceptions and Additions to NESC Provisions
305.120 Intent
305.130 Exemption
305.Table A Vertical Separation of Crossarms Carrying Conductors

AUTHORITY: Implementing Section 8-505 and authorized by Section 10-101 of the Public Utilities Act (Ill. Rev. Stat. 1989, ch. 111 2/3, pars. 8-505 and 10-101).

SOURCE: Effective June 1, 1963; rules repealed at 8 Ill. Reg. 19750, effective October 1, 1984; new Part adopted at 8 Ill. Reg. 19943, effective October 1, 1984; amended at 9 Ill. Reg. 11803, effective July 25, 1985; amended at 16 Ill. Reg. 6180 , effective April 15, 1992.

Section 305.20 Scope and Incorporation by Reference of Portions of the National Electric Safety Code (NESC)

a) This Part shall apply to electric utilities~~, telephone,~~ and ~~railroad public utilities.~~ those telecommunications carriers subject to Section 8-505 of the Public Utilities Act (Ill. Rev. Stat. 1989, ch. 111 2/3, par. 8-505).

b) The Illinois Commerce Commission adopts as its rules the following portions of the National Electric Safety Code (19~~84~~90 Edition, approved ~~July 15, 1983~~ June 26, 1989)

ILLINOIS COMMERCE COMMISSION

NOTICE OF ADOPTED AMENDMENT

1) Section 2 (Definitions of Special Terms).

2) Section 9 (Grounding Methods of Electric Supply and Communication Facilities).

3) Part 2 (Sections 20-287: Safety Rules for the Installation and Maintenance of Overhead Electric Supply and Communication Lines).

4) Part 3 (Sections 30-39: Safety Rules for the Installation and Maintenance of Underground Electric Supply and Communication Lines).

c) No incorporation in this Part includes any later amendment or edition.

(Source: Amended at 16 Ill. Reg. 6180 , effective April 15, 1992)

POLLUTION CONTROL BOARD

NOTICE OF ADOPTED AMENDMENTS

1) The Heading of the Part: MOBILE SOURCES

2) The Code Citation: 35 Ill. Adm. Code 240

3)

Section Number:	Adopted Action:
240.102	amend
240.107	new section
240.122	amend
240.140	new section
240.141	new section

4) Statutory Authority: Ill. Rev. Stat. 1991, ch. 111½, par. 1027

5) Effective Date of Rule(s) (Amendments, Repealer): April 7, 1992

6) Does this rulemaking contain an automatic repeal date?:
No
If so, please specify date: _____

7) Does this rule (amendment, repealer) contain incorporation by reference? yes, however the incorporations are pursuant to Section 6.02(a) of the Illinois Administrative Procedure Act and need not be approved by JCAR.

If "yes," was a copy of the approval form issued by JCAR attached to this rulemaking? No approval from JCAR was necessary as all the incorporation are pursuant to Section 6.02(a) of the Illinois Administrative Procedure Act.

8) Date Filed in Agency's Principal Office: February 28, 1992

9) Notice(s) of Proposal Published in Illinois Register: 15 Ill. Reg. 12109, August 30, 1991

10) Has JCAR issued a Statement of Objections to this (these) Rule(s)? If answer is "yes," please complete the following:
No

A) Statement of Objection: _____, ____ Ill. Reg. ____

B) Agency Response: _____, ____ Ill. Reg. _____.

C) Date Agency Response Submitted for Approval to JCAR:

11) Difference(s) between proposal and final version:

In Section 240.102 the following definitions were deleted: "Basic Penalty"; "Certification Level"; "Citation"; "Defective"; "Demonstration of Correction"; "Emission Control Level"; "Emission Control System"; "Inspection Procedure"; "Inspection Site"; "Insurance"; "Minimum Penalty"; "Officer"; "Owner"; "Post-repair Inspection"; "Post-repair test"; "Remove from Service"; "Repair Facility"; "Tampered"; "Test Opacity".

In addition the following Sections were deleted: Section 240.141 (as proposed), 240.143-240.148.

Section 240.142 was renumbered 240.141 and extensively reworded.

The definitions of "Opacity" and "Smokemeter or Opacimeter" were changed.

Section 240.107 was added.

Section 240.122: subsections were relabeled to comply with codification requirements.

12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will this rule (amendments, repealer) replace an emergency rule currently in effect? No

14) Are there any amendments pending on this Part? No

Section Numbers:	Proposed Action:	Ill. Reg. Citation:

15) Summary and Purpose of Rule(s):

A complete description of the rulemaking can be found in the Board's final Opinion and Order in R90-20, February 27, 1992. The Board has adopted an opacity standard based on a snap idle procedure and described the methodology to be used in performing the procedure. The standard correlates with the federal certification level for diesel engines. The Board has also eliminated the use of visual opacity as an enforcement tool. The remaining changes from the existing regulation relate to the use of the snap idle procedure and include the incorporation of documents and the addition of definitions.

16) Information and questions regarding this adopted rule shall be directed to:

Marie E. Tipsord
100 W. Randolph Street
State of Illinois Center
Suite 11-500
Chicago, IL 60601
(312) 814-4925

The full text of the adopted rule(s) begins on the following page:

TITLE 35: ENVIRONMENTAL PROTECTION
SUBTITLE B: AIR POLLUTION
CHAPTER I: POLLUTION CONTROL BOARD
SUBCHAPTER k: EMISSION STANDARDS AND LIMITATIONS FOR MOBILE SOURCES

PART 240
MOBILE SOURCES

SUBPART A: DEFINITIONS AND GENERAL PROVISIONS

SUBPART B: EMISSIONS

SUBPART C: HEAVY-DUTY DIESEL SMOKE OPACITY STANDARDS AND TEST PROCEDURES

AUTHORITY: Implementing Sections 9, 10 and 13 and authorized by Section 27 of the Environmental Protection Act (Ill. Rev. Stat. 1989, ch. 111-1/2, pars. 1009, 1010, 1013 and 1027).

SOURCE: Adopted as Chapter 2: Air Pollution, Part VII: Mobile Sources, filed and effective April 14, 1972; codified at 7 Ill. Reg. 13628; amended in R85-25, at 10 Ill. Reg. 11277, effective June 16, 1986; amended in R90-20 at 16 Ill. Reg. 6184, effective April 7, 1992.

NOTE: Capitalization denotes statuatory language.

SUBPART A: DEFINITIONS AND GENERAL PROVISIONS

Section 240.102 Definitions

All terms which appear in this Part have the definitions specified in this Part and 35 Ill. Adm. Code 201 and 211. Where conflicting definitions occur, the definitions of this Section apply in this Part.

"Diesel Engine": All types of internal-combustion engines in which air is compressed to a temperature sufficiently high to ignite fuel injected directly into the cylinder area.

"Diesel Locomotive": A diesel engine vehicle designed to move cars on a railway.

"Driver": The same meaning as defined in the Illinois Vehicle Code, Ill. Rev. Stat. 1989, ch. 95-1/2, par. 116.1.

"Fleet": Five or more vehicles.

"Full Power Position": The throttle position at which the engine fuel delivery is at maximum flow.

"Heavy Duty Vehicle": ~~A motor vehicle rated at more than 8000 pounds gross vehicle weight~~A vehicle with 8,000 pounds or greater manufacturer's maximum gross vehicle weight rating (GVWR).

"High Idle": That portion of a two-speed idle test conducted with the engine operating at a speed of approximately 2500 RPM.

"Idle Mode": That portion of a vehicle emission test procedure conducted with the engine disconnected from an external load and operating at minimum throttle.

"Light Duty Truck": A motor vehicle rated at 8000 pounds gross vehicle weight or less, which is designed for carrying more than 10 persons or designed for the transportation of property, freight or cargo, or is a derivative of such a vehicle.

"Light Duty Vehicle": A passenger car designed to carry not more than 10 persons.

"Model Year": The year of manufacture of a motor vehicle based upon the annual production period as designated by the manufacturer and indicated on the title and registration of the vehicle. If the manufacturer does not designate a production period for the vehicle, then "model year" means the calendar year of manufacture.

"Motor Vehicle": As used in this section "motor vehicle" shall have the same meaning as in the Illinois Vehicle Code (Ill. Rev. Stat. 1985~~9~~, ch. 95 1/2, par. 1-146).

"Opacity": ~~A condition which renders material partially of wholly impervious to the transmittance of light, and causes the obstruction of an observer's view~~That fraction of light, expressed in percent, which when transmitted from a source through a smoke-obscured path, is prevented from reaching the observer or instrument receiver.

~~"Persons Liable": All persons owning, operating or in charge or control of any equipment who shall cause or permit or participate in any violation of these rules and regulations either as owner, operator, lessee or lessor.~~

"Smokemeter or Opacimeter": An optical instrument designed to measure the opacity of smoke or diesel exhaust gases using the light extinction method.

"Snap idle Cycle": Rapidly depressing the accelerator pedal from normal idle to the full power position, holding the pedal in the position for no longer than ten seconds or until the engine reaches maximum speed, and fully releasing the pedal so that the engine decelerates to normal idle.

"Test Procedure": The preparation, preconditioning sequence and smoke opacity measurement processes using the snap idle cycle for determining compliance with Section 240.141.

"Two-Speed Idle Test": A vehicle emission test procedure consisting of the measurements of exhaust emission in high idle and idle modes.

(Source: Amended in R90-20 at 16 Ill. Reg. 6184, effective April 7, 1992.)

Section 240.107 Incorporations by Reference

The following materials are incorporated by reference and include no later editions or amendments:

a) Society of Automotive Engineers (SAE), 400 Commonwealth Drive, Warrendale, PA 15096: Report J255a Diesel Engine Smoke Measurement (August, 1978).

b) International Standards Organization (ISO), Case Postale 56, 1211 Geneve 20, Switzerland: ISO 393 (Working Draft, January 1991). Also available from American National Standards Institute (ANSI), 11 West 42nd Street, New York, NY 10036.

(Source: Added at 16 Ill. Reg. 6184, effective April 7, 1992.).

SUBPART B: EMISSIONS

Section 240.122 Diesel Engine Emission Standards for Locomotives

~~a) The visible emission standard in Section 240.121 shall not apply to diesel engines.~~

~~b) With the exception of subsection (c), diesel engines manufactured before January 1, 1970, shall not be operated in such a manner as to emit smoke which is equal to or greater than 30% opacity except for individual smoke puffs. Individual puffs of smoke shall not exceed 15 seconds in duration.~~

~~c)~~

~~1) Diesel engines shall be operated only on the specific fuels as specified in the engine manufacturers' specifications for that specific engine, or on fuels exceeding engine manufacturers' specifications.~~

~~2) Persons liable for operating diesel engine fleets wholly within standard metropolitan statistical areas shall furnish to the Environmental Protection Agency, once each year, proof that the fuel purchased and used in their operations conform to subsection (c)(1).~~

~~d) All diesel engines operated on public highways in Illinois coming from out of the State shall conform to subsection (b).~~

~~e)~~

~~1)~~a) No person shall cause or allow the emission of smoke from any diesel locomotive in the State of Illinois to exceed thirty percent (30%) opacity.

~~2)~~b) Subsection ~~(e)(1)~~(a) shall not apply to:

~~A)~~1) Smoke resulting from starting a cold locomotive: for a period of time not to exceed 30 minutes.

~~B)~~2) Smoke emitted while accelerating under load from a throttle setting other than idle to a higher throttle setting: for a period of time not to exceed 40 seconds.

~~C)~~3) Smoke emitted upon locomotive loading following idle: for a period of time not to exceed 2 minutes.

~~D)~~4) Smoke emitted during locomotive testing, maintenance, adjustment, rebuilding, repairing or breaking in: for a period of time not to exceed 3 consecutive minutes and an aggregate of 10 minutes in any 60 minute period.

~~E)~~5) Smoke emitted by a locomotive which because of its age or design makes replacement or retrofit parts necessary to achieve smoke reduction unavailable. These locomotives shall be retired at the earliest possible time.

(Source: Amended in R90-20 at 16 Ill. Reg. 6184, effective April 7, 1992.)

SUBPART C: HEAVY-DUTY DIESEL SMOKE OPACITY STANDARDS AND TEST PROCEDURES

Section 240.140 Applicability

This Subpart applies to all on-road diesel-powered vehicles with a 8,000 pounds or greater manufacturer's maximum gross vehicle weight rating (GVWR) operating in the State of Illinois.

(Source: Added in R90-20 at 16 Ill. Reg. 6184, effective April 7, 1992.)

Section 240.141 Heavy-Duty Diesel Vehicle Smoke Opacity Standards and Test Procedures

a) The standard for heavy-duty diesel vehicle smoke opacity is as follows:

1) No 1991 or later model year heavy-duty diesel-powered vehicle with a federal peak smoke engine certification operating on the roadways within the State of Illinois shall exceed forty percent (40%) peak smoke opacity when tested in accordance with subsections (b) and (c).

2) Except for subsection (a)(1), no heavy-duty diesel-powered vehicle operating on the roadways within the State of Illinois shall exceed fifty-five percent (55%) peak smoke opacity when tested in accordance with subsections (b) and (c).

b) The smoke opacity measurement shall be carried out using a light-extinction type opacimeter capable of measuring and recording opacity continuously during the snap idle testing cycle. A strip chart recorder or an equivalent or better recording device shall be used in concert with the opacimeter to record opacity continuously, including peak values. The opacimeter shall be capable of providing opacity readings with sufficient resolution to obtain 0.5 second-averaged values. The peak 0.5 second-averaged value shall be used for showing compliance with the standard in subsection (a). Where the response time of the instrument is such that opacity is being measured at smaller than 0.5 second intervals, the meter shall have the capability of providing or allowing the calculation of 0.5 second-averaged values.

1) The opacimeter shall be either an in-line full-flow opacimeter; end-of-line or plume type full-flow opacimeter; or a sampling type partial flow

opacimeter. The opacimeter and recording devices shall be calibrated according to manufacturers's specifications. Corrections for the effect of exhaust stack diameter shall apply to opacity measurements made using an end-of-line full-flow opacimeter; and

2) The opacimeter and recorder shall comply with specifications in the International Standards Organization ISO 393 and in Society of Automotive Engineers (SAE) report number J255a entitled "Diesel Engine Smoke Measurement", incorporated by reference in Section 240.107.

c) The test procedure using the snap idle cycle shall occur under when the engine is at normal operating temperature. The test shall consist of preparation, preconditioning, and testing phases.

1) In the preparation phase, the vehicle shall be placed at rest, the transmission shall be placed in neutral, and the vehicle wheels shall be properly restrained to prevent any rolling motion. In the event of a roadside test, it shall be acceptable under this Section for the driver to apply the brakes during the test.

2) In the preconditioning phase, the vehicle shall be put through a snap idle cycle three or more times until successive measured smoke opacity readings are within ten percent (10%) of each other. The opacimeter shall be rechecked prior to the preconditioning sequence to determine that its zero and span setting are adjusted to manufacturer's specifications.

3) In the testing phase, the vehicle shall be put through the snap idle cycle three times.

A) The smoke opacity shall be measured during the preconditioning and testing phases with an opacimeter meeting the requirements of subsection (b) and shall be recorded continuously on the recorder during each snap idle cycle. The maximum 0.5 second averaged

value recorded during each snap idle cycle shall be the smoke opacity reading.

B) The average of the three smoke opacity readings shall be used to determine compliance with the opacity standard in subsection (a).

d) Pursuant to Section 28.1(b) of the Act and 35 Ill. Adm. Code 106.Subpart G, any person petitioning for an adjusted standard from the 55% peak smoke opacity standard in subsection (a)(2) for DDC 1987-1990 Series 60 engines shall establish its justifications by providing the following information at a minimum:

1) The specific characteristics common only to all the 1987-1990 Series 60 engines that result in noncompliance with the 55% opacity standard.

2) All USEPA certification and snap/idle test data.

3) Economic and technical data related to the logistical or other perceived difficulties encountered or that may be encountered if the existing 1987-1990 Series 60 engine software were to be reprogrammed so as to come into compliance.

4) The alternative opacity standard proposed and supporting data.

5) Supporting data showing that THE REQUESTED STANDARD WILL NOT RESULT IN ENVIRONMENTAL OR HEALTH EFFECTS SUBSTANTIALLY AND SIGNIFICANTLY MORE ADVERSE THAN THE EFFECTS CONSIDERED BY THE BOARD IN ADOPTING THE RULE OF GENERAL APPLICABILITY. (Section 28.1(c)(3) of the Act).

(Source: Added in R90-20 at 16 Ill. Reg. 6184, effective April 7, 1992.)

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

1) The Heading of the Part: DIAGNOSIS RELATED GROUPING (DRG) PROSPECTIVE PAYMENT SYSTEM (PPS)

2) Code Citation: 89 Ill. Adm. Code 149

3) Section Numbers: Adopted Action:

149.5	Amendment
149.25	Amendment
149.50	Amendment
149.75	Amendment
149.100, 149.105	Amendment
149.125	Amendment
149.150	Amendment
149.175	Repealed
149.200	Repealed
149.205	Repealed
149.225	Repealed
149.250	Repealed
149.275	Repealed
149.300	Repealed
149.305	Repealed
149.325	Repealed

4) Statutory Authority: Sections 5-5.1 et seq. and 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, Ch. 23, Pars. 5-5.1 et seq. and 12-13)

5) Effective Date of Adopted Amendments: March 27, 1992

6) Does this rulemaking contain an automatic repeal date?
___Yes _X_No

7) Do these Adopted Amendments contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: March 27, 1992

9) Notice of Proposal Published in Illinois Register:

November 8, 1991 (15 Ill. Reg. 15931)

10) Has JCAR issued a Statement of Objections to these Adopted Amendments? If answer is "yes", please complete the following: No

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

11) Differences between proposal and final version:

The Heading of the Part was changed from ILLINOIS COMPETITIVE ACCESS AND REIMBURSEMENT EQUITY (ICARE) PROGRAM to DIAGNOSIS RELATED GROUPING (DRG) PROSPECTIVE PAYMENT SYSTEM (PPS).

Section 149.25

Subsection (a)(4)(A) - changed "149.10" to 149.100".

Subsection (a)(5) - a space was inserted between subsections (a)(5)(A) and (a)(5)(B).

Subsection (a)(5)(A) - changed "Atypically" to "A typically".

Subsection (a)(5)(B) - add "Certain" to begin subsection; decapitalize "Costs".

Section 149.50

Subsection (c) - capitalized "section".

Subsection (c)(2)(A) - changed "physicial" to "physical".

Section 149.75

Subsection (d)(1) - changed "(c)(2)" to "(d)(2)".

Subsection (d)(2) - changed "(c)(1)" to "(d)(1)".

Subsection (d)(5)(A) - changed "diagnostics" to "diagnostic".

Subsection (d)(5)(B) - changed "(c)(5)(A)" to "(d)(5)(A)".

Subsection (g) - add "Length of Stay," after "Admissions,".

Subsection (g)(1) - add "length of stay," after "admissions,".

Subsection (g)(1)(A) - add "inappropriate length of stay or discharge," after "admission,".

Subsection (g)(1)(C) - add "(a)" after "148.240".

Subsection (g)(2) - add "The date of the Advisory Notice is counted as one day." at the end of this subsection.

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Subsection (g)(3) - add "," after "admissions"; add "length of stay" before "and billing".

Subsection (e) following subsection (f) - changed the subsection to "g)".

Subsection (h)(1) - changed both "(e)"s to "(g)"s.

Subsection (h)(1)(A) - changed "fee for service" to "fee-for-service".

Section 149.100

Subsection (a)(2)(B)(i) - changed "89 Illinois Administrative" to "89 Ill. Adm.".

Subsection (b)(3) - add "(2)" after "149.125(a)".

Subsection (b)(4) - changed "191" to "1991".

Subsection (c)(2) - add "," after "centers"; delete "and" before "Medicare"; add ", and rural hospitals deemed urban".

Subsection (c)(4) - delete one of the "89 Ill. Adm. Code" that is in this subsection right after each other.

Subsection (d) - replaced "subsections (b)(1) and (b)(2)" with "subsection (c)".

Section 149.105

Subsection (a)(2) - changed "not" to "or".

Subsection (b)(1) - changed "made" to "make".

Subsection (b)(3) - changed "(b)(3)" to "(b)(2)".

Section 149.125

Subsection (a)(1) - delete "(1)".

Subsection (a)(3) - capitalized "the" after "Hospitals."; changed "Deprtment" to "Department"; capitalized "code".

Subsection (b)(2) - add the language of subsection (c) to the end of this subsection.

Subsection (c) - delete the subsection since the language is added to subsection (b)(2).

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 149.150

Subsection (a) - changed "(d)" to "(c)".

Subsection (c)(1)(A) - add "(" before "i.e.,".

Subsection (c)(3) - changed "costs" to "factor"; changed "(b)(2)(C)" to "(c)(3)".

Subsection (c)(4)(B) - add "(" before "i.e.,"; changed "backet" to "basket".

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will these Adopted Amendments replace Emergency Amendments currently in effect? Yes

14) Are there any Amendments pending on this Part? No

15) Summary and Purpose of Adopted Amendments: This rulemaking sets forth the basis of payment for inpatient hospital services under the Diagnostic Related Grouping (DRG) Prospective Payment System (PPS). This rulemaking also deletes provisions related to the Illinois Competitive Access and Reimbursement Equity Program (ICARE).

These changes are estimated to increase the Department's aggregate expenditures for inpatient hospital services by $510 million in Fiscal Year 1992.

16) Information and questions regarding these Adopted Amendments shall be directed to:

Name: Joanne Jones
Bureau of Rules and Regulations

Address: Illinois Department of Public Aid
Jesse B. Harris Building II
100 South Grand Avenue East, 3rd Floor
Springfield, Illinois 62762

Telephone: (217) 524-3215

The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 149
~~ILLINOIS COMPETITIVE ACCESS AND REIMBURSEMENT EQUITY (ICARE) PROGRAM~~
DIAGNOSIS RELATED GROUPING (DRG)
PROSPECTIVE PAYMENT SYSTEM (PPS)

Section

AUTHORITY: Implementing Article II of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1989, ch. 111 1/2, par. 6503-1 et seq.) and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13)

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

SOURCE: Recodified from 89 Ill. Adm. Code 140.940 thru 140.972 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. at 12095, effective July 15, 1988; amended at 13 Ill. Reg. 554, effective January 1, 1989; amended at 13 Ill. Reg. 15070, effective September 15, 1989; amended at 15 Ill. Reg. 1826, effective January 28, 1991; emergency amendment at 15 Ill. Reg. 16308, effective November 1, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 6195, effective March 27, 1992.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE.

Section 149.5 ~~Illinois Competitive Access and Reimbursement Equity (ICARE) Program~~ Diagnosis Related Grouping (DRG) Prospective Payment System (PPS)

~~a) Pursuant to Public Act 83 1243 the Department, in consultation with the Hospital Services Procurement Advisory Board, shall negotiate and enter into contracts with hospitals for the provision of inpatient hospital care to recipients. The Department shall refuse payment after closure of the ICARE area as defined in Section 149.125 for inpatient hospital care provided to recipients by non contracting hospitals in the ICARE area except as identified in Section 149.205.~~

~~b) Recipients of Medical assistance, regardless of where they reside, may choose to receive inpatient hospital services at either a contracting hospital or a member of a contracting group of hospitals located within an ICARE area or at a participating hospital located within a non contracting area. An eligible recipient's freedom of choice to seek inpatient hospital care at a non contracting hospital located within an ICARE area is limited by the provisions of Section 149.205.~~

Sections 149.25 through 149.150 describe:

a) The basis of payment for inpatient hospital services under the DRG PPS and sets forth the general basis for the system;

b) Classifications of hospitals that are included and

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 149.5 ~~Illinois-Competitive-Access-and-Reimbursement Equity-(ICARE)-Program~~Diagnosis Related Grouping (DRG) Prospective Payment System (PPS) (Cont'd)

excluded from the DRG PPS and the requirements governing inclusion or exclusion of hospitals in the system as a result of changes in their classification;

c) Conditions that must be met for a hospital to receive payment under the DRG PPS;

d) The methodology by which DRG prospective rates are determined;

e) The methodology for determining additional payments for outlier cases;

f) The rules for special treatment of certain facilities; and

g) The types, amounts and methods of payment to hospitals under the DRG PPS.

(Source: Amended at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.25 ~~Definition-of-Terms~~General Provisions

~~a) The-following-terms-as-used-in-these-rules-are-defined-as-follows:~~

~~b) "AMI"-means-those-persons-receiving-Medical-Assistance-under-Article-VII-of-the-Illinois-Public-Aid-Code-(Ill.-Rev.-Stat.-1983,-ch.-23,-para.-7-1-et-seq.);~~

~~c) "Board"-means-"Hospital-Services-Procurement-Advisory-Board";~~

~~d) "Contracting-Hospital"-means-a-hospital-awarded-a-contract-for-the-provision-of-inpatient-hospital-care-through-the-ICARE-Program;~~

~~e) "Department"-means-the-Illinois-Department-of-Public-Aid;~~

~~f) "Director"-means-the-Director-of-the-Illinois-Department-of-Public-Aid;~~

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~~g) "Direct-Teaching-Costs"-means-direct-teaching-costs-as-defined-by-Medicare-at-42-CFR-405,421-(1984);~~

~~h) "HOSPITAL"-MEANS-ANY-INSTITUTION,-PLACE,-BUILDING,-AGENCY,-PUBLIC-OR-PRIVATE,-WHETHER-ORGANIZED-FOR-PROFIT-OR-NOT-FOR-PROFIT,-WHICH-IS-SUBJECT-TO-LICENSURE-BY-THE-ILLINOIS-DEPARTMENT-OF-PUBLIC-HEALTH-UNDER-THE-HOSPITAL-LICENSING-ACT-(Ill.-Rev.-Stat.-1983,-ch.-111-1/2,-par.-142-et-seq.)-or-meeting-all-comparable-conditions-and-requirements-in-effect-for-the-state-in-which-it-is-located,-AND-THE-UNIVERSITY-OF-ILLINOIS-HOSPITAL-AS-DEFINED-IN-"AN-ACT-IN-RELATION-TO-THE-FOUNDING-AND-OPERATION-OF-THE-UNIVERSITY-OF-ILLINOIS-HOSPITAL-AND-THE-CONDUCT-OF-UNIVERSITY-OF-ILLINOIS-HEALTH-CARE-PROGRAMS"-(Ill.-Rev.-Stat.-1983,-ch.-23,-par.-1371-et-seq.)-(statutory-language-from-Section-3-1(f)-of-the-Illinois-Health-Finance-Reform-Act,-Ill.-Rev.-Stat.-1984-Supp.,-ch.-111-1/2,-par.-6503-1(f));~~

~~i) "ICARE-Program"-means-Illinois-Competitive-Access-and-Reimbursement-Equity-Program;~~

~~j) "ICARE-area"-means-a-geographic-area-designated-by-the-Department-as-eligible-for-the-Illinois-Competitive-Access-and-Reimbursement-Equity-(ICARE)-Program-and-determined-by-the-Department-as-eligible-for-the-Illinois-Competitive-Access-and-Reimbursement-Equity-(ICARE)-Program-to-be-an-entity-based-upon-population,-travel-time,-natural-boundaries,-and-customary-health-services-delivery-patterns;~~

~~k) "INPATIENT"-MEANS-A-PATIENT-WHO-IS-PROVIDED-WITH-ROOM,-BOARD,-AND-CONTINUOUS-GENERAL-NURSING-SERVICES-IN-AN-AREA-OF-THE-HOSPITAL-WHERE-PATIENTS-GENERALLY-STAY-AT-LEAST-OVERNIGHT-(Ill.-Rev.-Stat.-1984-Supp.,-ch.-111-1/2,-par.-6503-1(g));~~

~~l) "Inpatient-hospital-care"-means-the-care-provided-to-a-recipient-after-admission-to-a-hospital-while-he-is-in-a-hospital,-including-all-such-related-services-as-historically-reported-on-the-hospital's-Medicaid-cost-report-but-shall-not-include-inpatient-hospital-care-provided-to-recipients-enrolled-in-health-maintenance-organizations-under-contract-with-the-Department;~~

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Section 149.25 ~~Definition of Terms~~ General Provisions (Cont'd)

~~m) "Inpatient services" means the same as inpatient hospital care;~~

~~n) "LICENSED PHYSICIAN" MEANS A PHYSICIAN LICENSED TO PRACTICE MEDICINE IN ALL OF ITS BRANCHES (Ill. Rev. Stat. 1984 Supp., ch. 111 1/2, par. 6503 1(i));~~

~~o) "Medicaid" means Title XIX of the federal Social Security Act (42 U.S.C.A. §§ 1396 et seq. (1983));~~

~~p) "MEDICAL ASSISTANCE" MEANS PAYMENTS MADE BY THE ILLINOIS DEPARTMENT OF PUBLIC AID FOR HEALTH CARE SERVICES RENDERED TO PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE UNDER ARTICLES V, VI AND VII OF THE ILLINOIS PUBLIC AID CODE (Ill. Rev. Stat. 1983, ch. 23, pars. 5 1 et seq., 6 1 et seq. and 7 1 et seq.) (statutory language from Ill. Rev. Stat. 1984 Supp., ch. 111 1/2, par. 6503 1(k));~~

~~q) "Medicare" means Title XVIII of the federal Social Security Act;~~

~~r) "Non Contracting Hospital" means those hospitals which either elect not to enter into negotiations with the Department for the provision of inpatient services under the ICARE Program, or who have not been awarded a contract by the Department for the provision of inpatient services under the ICARE Program. Non contracting applies only to those hospitals located within a geographic area defined by the Department as eligible for the ICARE Program;~~

~~s) "RECIPIENT" MEANS A RECIPIENT OF AID UNDER ARTICLES V, VI OR VII OF THE ILLINOIS PUBLIC AID CODE (Ill. Rev. Stat. 1983, ch. 23, pars. 5 1 et seq., 6 1 et seq., or 7 1 et seq.) (statutory language from Ill. Rev. Stat. 1984 Supp., ch. 111 1/2, par. 6503 1(n)).~~

a) Basis of Payment

1) Payment on a Per Discharge Basis

A) Under the DRG PPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to

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Section 149.25 ~~Definition of Terms~~ General Provisions (Cont'd)

persons receiving coverage under the Medicaid Program.

B) The DRG prospective payment rate for each discharge (as defined in subsection (b) below) is determined according to the methodology described in Sections 149.100 and 149.150, as appropriate. An additional payment is made, in accordance with Sections 149.105 and 149.125, as appropriate.

2) Payment in Full

(A) The DRG prospective payment amount paid for inpatient hospital services is the total Medicaid payment for the inpatient operating costs (as described in subsection (a)(3) below) incurred in furnishing services covered under the Medicaid Program.

B) Except as provided for in subsection (b) below, the full DRG prospective payment amount, as determined under Sections 149.100 and 149.150, as appropriate, is made for each stay during which there is at least one Medicaid eligible day of care.

3) Inpatient Operating Costs. The DRG PPS provides a payment amount for inpatient operating costs, including:

A) Operating costs for routine services (as described in 42 CFR 413.53(b), revised as of September 1, 1990), such as the costs of room, board, and routine nursing services;

B) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;

C) Special care unit operating costs (intensive care type unit services as described in 42 CFR 413.53(b), revised as of September 1, 1990); and

Section 149.25 ~~Definition of Terms~~ General Provisions (Cont'd)

D) Malpractice insurance costs related to services furnished to inpatients.

4) Excluded Costs/Services. The following inpatient hospital costs are excluded from the DRG prospective payment amounts:

A) Transplant costs including acquisition costs incurred by approved transplantation centers as described in 89 Ill. Adm. Code 148.80. Kidney and cornea transplant costs shall be reimbursed under the appropriate methodology described in Sections 149.100 and 149.150 or in 89 Ill. Adm. Code 148.240 through 148.300. Kidney acquisition costs shall be reimbursed in accordance with Section 149.150(c)(5).

B) Costs of psychiatric services incurred by a provider enrolled with the Department to provide those services (category of service 21). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).

C) Costs of nonemergency psychiatric services incurred by a provider that is not enrolled with the Department to provide those services (category of service 21). Such services shall not be eligible for reimbursement.

D) Costs of emergency psychiatric services exceeding the maximum of three days emergency treatment incurred by a provider that is not enrolled with the Department to provide those services (DRGs 424-432). Such services exceeding the maximum of 3 days shall not be eligible for reimbursement.

E) Costs of physical rehabilitation services incurred by a provider enrolled with the Department to provide those services (category of service 22). Such services shall be reimbursed under 89 Ill. Adm. Code 148.270(b).

Section 149.25 ~~Definition of Terms~~ General Provisions (Cont'd)

5) Additional Payments to Hospitals. In addition to payments based on the DRG prospective payment rates, hospitals will receive payments for the following:

A) A typically long or extraordinarily costly (outlier) case, as described in 89 Ill. Adm. Code 149.105.

B) Certain costs excluded from the prospective payment rate under subsection (a)(4) above.

C) The cost of serving a disproportionately high share of low income patients and providing uncompensated care to low income persons (as defined and determined in Section 149.125).

D) Uncompensated care costs for nondisproportionate share hospitals (as defined and determined in Section 149.125).

E) Kidney Acquisition Costs in accordance with Section 149.150(c)(5).

F) Administration of blood clotting factor to hemophiliacs who are hospital inpatients in accordance with Section 149.150(c)(6).

b) Discharges and Transfers

1) Discharges. A hospital inpatient is considered discharged when any of the following occurs:

A) The patient is formally released from the hospital except when the patient is transferred to another hospital or a distinct part unit as described in Section 149.50(d) (see subsection (b)(2) below).

B) The patient dies in the hospital.

2) Transfers. A hospital inpatient is considered transferred when the patient is placed in the care of another hospital or a distinct part unit as described in Section 149.50(d).

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Section 149.25 ~~Definition of Terms~~ General Provisions (Cont'd)

3) Payment in Full to the Discharging Hospital. The hospital discharging an inpatient (subsection (b)(1)(A) above) is paid in full, in accordance with subsection (a)(2) above unless the discharging hospital or distinct part unit is excluded from the DRG PPS as described in Section 149.50(b), (c) and (d). In the event the discharging hospital or distinct part unit is excluded from the DRG PPS, the excluded hospital or distinct part unit shall receive payment in full in accordance with 89 Ill. Adm. Code 148.240 through 148.300.

4) Payment to a Hospital Transferring an Inpatient to Another Hospital or Distinct Part Unit

A) A hospital reimbursed under the DRG PPS that transfers an inpatient, under the circumstances described in subsection (b)(2), is paid a per diem rate for each day of the patient's stay in that hospital but the total reimbursement shall not exceed the amount that would have been paid under Section 149.100 if the patient had been discharged. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under Section 149.100) by the geometric length of stay for the specific DRG to which the case is classified.

B) Except, if a discharge is classified into DRG 385 (neonates, died or transferred to another acute care facility) or DRG 456 (burns, transferred to another acute care facility), and the hospital is reimbursed under the DRG PPS, the transferring hospital is paid in accordance with subsection (a)(2).

C) A transferring hospital reimbursed under the DRG PPS may qualify for an additional payment for extraordinarily high cost cases that meet the criteria for cost outliers as described in Section 149.105.

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Section 149.25 ~~Definition of Terms~~ General Provisions (Cont'd)

D) A hospital or distinct part unit excluded from the DRG PPS, as described in Section 149.50(b), (c) or (d), that transfers an inpatient under the circumstances described in subsection (b)(2) of this Section, is reimbursed in accordance with 89 Ill. Adm. Code 148.240 through 148.300.

c) Admissions Prior to September 1, 1991. With respect to admissions prior to September 1, 1991, hospitals will receive their per diem reimbursement rate that was in effect July 1, 1991 for each covered day of care provided through the discharge of the patient.

d) DRG Classification System

1) The Department will utilize the HCFA Medicare grouper, Version 8.0, modified to handle additional DRGs and ICD-9-CM codes, as defined by the Department, to place claims into DRG payment classifications.

2) The Department will define additional DRGs that, for hospitals designated as Level III perinatal centers by the Illinois Department of Public Health, replace DRG 385 (neonates, died or transferred to another acute care facility), DRG 386 (extreme immaturity or respiratory distress syndrome, neonate), DRG 387 (prematurity with major problems) and DRG 389 (full term neonate with major problems).

(Source: Amended at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.50 ~~Notification of Negotiations~~ Hospital Services Subject to and Excluded from the DRG Prospective Payment System

~~The Department shall notify in writing by certified or registered mail, return receipt requested, all hospitals within an ICARE area that it intends to open negotiations for the purpose of contracting for inpatient hospital care provided to recipients. The hospital shall have ten (10) calendar days after receipt of the Department's notification to notify the~~

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Section 149.50 ~~Notification of Negotiations~~ Hospital Services Subject to and Excluded from the DRG Prospective Payment System (Cont'd)

~~Department of its interest, or lack of interest, in participating in the ICARE Program. Direct contact to the Department by the hospital within the (10) calendar days is acceptable, but must be followed by certified or registered mail, notifying the Department of the hospital's intent to participate. Failure of the hospital to respond within ten (10) calendar days shall result in exclusion from negotiations and thus exclusion from the possibility of receiving a contract under the ICARE Program.~~

a) Hospital Services Subject to the DRG Prospective Payment System

1) Except for services described in Section 149.25(a)(4) and subsection (b)(2) below, all covered inpatient hospital services furnished to persons receiving coverage under the Medicaid Program are paid for under the DRG PPS.

2) Inpatient hospital services will not be paid for under the DRG PPS under any of the following circumstances:

A) The services are furnished by a hospital (or distinct part hospital unit) explicitly excluded from the DRG PPS under subsections (c) through (d).

B) The services are furnished by a nonparticipating out-of-state hospital (as described in subsection (c)(5)).

C) The services are furnished by a hospital that elects to be reimbursed under special arrangements (as described in subsection (c)(6)) in the transition period of DRG PPS implementation.

D) The services are furnished by a sole community hospital (as defined in Section 149.125(b)) that has elected to be excluded from the DRG PPS in accordance with subsection (c)(7).

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Section 149.50 ~~Notification of Negotiations~~ Hospital Services Subject to and Excluded from the DRG Prospective Payment System (Cont'd)

E) The payment for services is covered by a health maintenance organization (HMO).

b) Excluded Hospitals and Hospital Units: General Rules

1) Criteria. A hospital will be excluded from the DRG PPS if it meets the criteria for one or more of the excluded classifications described in subsection (c) below.

2) Alternate Reimbursement System. All excluded hospitals (and excluded distinct part hospital units, as described in subsection (d) below) are reimbursed under the Alternate Reimbursement Systems set forth in 89 Ill. Adm. Code 148.240 through 148.300 with the exception of those hospitals described in subsection (c)(8). The hospitals described in subsection (c)(8) are reimbursed in accordance with 89 Ill. Adm. Code 148.160 or 148.170, as appropriate.

c) Excluded Hospitals: Classifications. Hospitals that meet the requirements for the classifications set forth in this Section may not be reimbursed under the DRG Prospective Payment System.

1) Psychiatric Hospitals. A psychiatric hospital must:

A) Be primarily engaged in providing, by or under the supervision of psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and

B) Be enrolled with the Department as a psychiatric hospital and have a Provider Agreement to participate in the Medicaid Program.

2) Rehabilitation Hospitals. A rehabilitation hospital must:

A) Hold a valid license as a physical rehabilitation hospital; and

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Section 149.50 ~~Notification of Negotiations~~ Hospital Services Subject to and Excluded from the DRG Prospective Payment System (Cont'd)

B) Be enrolled with the Department as a rehabilitation hospital and have a Provider Agreement to participate in the Medicaid Program.

3) Children's Hospitals. A children's hospital must:

A) Be engaged in furnishing services to inpatients who are predominately individuals under 18 years of age; and

B) Have a Provider Agreement to participate in the Medicaid Program.

4) Long Term Care Hospitals. A long term care hospital must:

A) Not be a psychiatric hospital, as described in subsection (c)(1) above, a rehabilitation hospital as described in subsection (c)(2) above, or a children's hospital as described in subsection (c)(3) above and must have an average length of inpatient stay greater than 25 days; as computed by dividing the number of total inpatient days (less leave or pass days) by the number of total discharges for the most recent fiscal year (i.e., Fiscal Year 1991 for Fiscal Year 1992 payments); and

B) Have a Provider Agreement to participate in the Medicaid Program.

5) Hospitals Outside of Illinois that are Exempt from Cost Reporting Requirements. A hospital is excluded from the DRG PPS if it meets the following definition: a nonparticipating out-of-state hospital is a hospital from out-of-state that provides fewer that 200 Illinois Medicaid days annually and that does not file an Illinois Medicaid cost report.

6) Hospitals Reimbursed Under Special Arrangements. During the transition period of the DRG PPS implementation, hospitals that, on August 31,

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Section 149.50 ~~Notification of Negotiations~~ Hospital Services Subject to and Excluded from the DRG Prospective Payment System (Cont'd)

1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991.

7) Sole Community Hospitals. Hospitals described in Section 149.125(b), which have elected to be excluded from the DRG PPS.

8) County-Owned Hospitals and State-Owned Hospitals. County-owned hospitals and State-owned hospitals located in a county with a population greater than three million are excluded from the DRG system and are reimbursed under unique hospital-specific reimbursement methodologies as described in 89 Ill. Adm. Code 148.160 and 148.170.

d) Excluded Distinct Part Hospital Units.

1) Distinct Part Psychiatric Units. With the exception of those hospitals described in subsections (c)(1) through (c)(8), a hospital enrolled with the Department to provide inpatient psychiatric services (category of service 21) shall be excluded from the DRG PPS for the reimbursement of such inpatient psychiatric services and shall be reimbursed in accordance with 89 Ill. Adm. Code 148.270(b).

2) Distinct Part Rehabilitation Units. With the exception of those hospitals described in subsections (c)(1) through (c)(8), a hospital enrolled with the Department to provide inpatient rehabilitation services (category of service 22) shall be excluded from the DRG PPS for the reimbursement of such inpatient rehabilitation services and shall be reimbursed in accordance with 89 Ill. Adm. Code 148.270(b).

(Source: Amended at 16 Ill. Reg. 6195, effective March 27, 1992)

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Section 149.75 ~~Hospital Participation in IGARE Program~~ Negotiations Conditions for Payment Under the DRG Prospective Payment System

~~a) Upon notification by the Department that negotiations are scheduled for an IGARE area or areas, each hospital shall choose one of the following two alternatives for the method of its participation:~~

~~1) The hospital may elect to negotiate with the Department for the provision of inpatient hospital care to recipients as an individual hospital; or~~

~~2) The hospital may elect to negotiate with the Department for the provision of inpatient hospital care to recipients as a member of a group of hospitals providing inpatient hospital care to recipients living or residing in an IGARE area or IGARE areas in which the Department has notified hospitals of its intent to open negotiations. Each group shall be treated by the Department as a single contracting entity. No more than three (3) representatives of the group may attend negotiations. Offers made by the identified representative or representatives of the group shall be binding upon each member of the group. The negotiation procedures contained in Section 149.100 shall apply to all negotiations whereby a group of hospitals negotiates with the Department as a single contracting entity.~~

~~b) Nothing in subsection (a) shall prevent those hospitals which provide services under contract with another hospital from negotiating with the Department as an individual hospital.~~

~~c) Each hospital must notify the Department by registered or certified mail, return receipt requested, no later than fourteen (14) calendar days after the first meeting of its decision to participate in the IGARE Program as either a member of a group of hospitals or as an individual hospital.~~

~~d) In cases in which a group of hospitals negotiates with the Department as a single contracting entity, the Department shall have the right at any time during negotiations to terminate such negotiations and~~

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Section 149.75 ~~Hospital Participation in IGARE Program~~ Negotiations Conditions for Payment Under the DRG Prospective Payment System (Cont'd)

~~negotiate and enter into a contract or contracts with one or more of the hospitals in the group. At any time during the negotiations, all hospitals comprising a group of hospitals negotiating with the Department as a group may collectively and unanimously request in writing that the Department terminate negotiations with those hospitals as a group. In determining whether to terminate negotiations with hospitals as a group, the Department shall consider the status and progress of the negotiations with the group to date and shall additionally examine whether the individual hospitals in the group offer types of services which are not offered by other hospitals in the group and which complement the type of services offered by the hospitals in that group to ensure the availability of inpatient hospital services as provided in Sections 149.105(a)(3) and (4). An individual hospital previously negotiating as a member of a group of hospitals for which group negotiations have been terminated has the right to negotiate with the Department as a single hospital, if such hospital, within 10 days of receiving notification of the Department's termination of negotiations with the group of hospitals, notifies the Department, by certified or registered mail, return receipt requested, of its interest in participating in the IGARE Program as a single hospital.~~

a) General Requirements

1) A hospital must meet the conditions of this Section to receive payment under the DRG PPS for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.

2) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicaid clients, the Department may, as appropriate:

A) Withhold Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

Section 149.75 ~~Hospital Participation in ICARE Program Negotiations~~ Conditions for Payment Under the DRG Prospective Payment System (Cont'd)

B) Terminate the hospital's Provider Agreement.

b) Hospital Utilization Control

Hospitals shall comply with the hospital utilization control requirements of 42 CFR, Ch. IV, Part 456, Subparts C, D and G, as appropriate.

c) Medical Review Requirements: Admissions and Quality Review

Hospital utilization review committees, a subgroup of the utilization review committee, or the hospital's designated professional review organization (PRO) shall review, on an ongoing basis, the following:

1) The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.

2) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Section 149.105.

3) The validity of the hospital's diagnostic and procedural information.

4) The completeness, adequacy and quality of the services furnished in the hospital.

5) Other medical or other practices with respect to program participants or billing for services furnished to program participants.

d) Medical Review Requirements: DRG Validation

1) Physician attestation. Beginning with admissions on or after September 1, 1991, for which the discharge occurs on or after December 15, 1991, the attending physician must, shortly before, at, or shortly after discharge (but before a claim is submitted), attest to the principal diagnosis, secondary diagnoses, and names of major

Section 149.75 ~~Hospital Participation in ICARE Program Negotiations~~ Conditions for Payment Under the DRG Prospective Payment System (Cont'd)

procedures performed. The information must be in writing in the medical record and, except as provided in subsection (d)(2) below, the physician must sign the statement. Below the diagnostic and procedural information, and on the same page, the following statement must immediately precede the physician's dated signature: "I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge." The physician's name must be typed or clearly printed and appear on the same page as the physician's signature.

2) Alternative signature requirement. The attending physician's signature, along with the other information required in subsection (d)(1), may be provided by electronic means through a hospital data system if the hospital's Title XVIII (Medicare) intermediary has determined that the hospital data system meets the guidelines established by the Health Care Financing Administration, U.S. Department of Health and Human Services, under the Medicare Program.

3) DRG Validation. The Department or its designee may require and perform prepayment review and/or postpayment review of specific diagnosis and procedure codes.

4) Sample Reviews

A) The Department, or its designee, may review a random sample of discharges to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records.

B) Code validation must be done on the basis of a review of medical records and, at the

Section 149.75 ~~Hospital Participation in ICARE Program~~ Negotiations-Conditions for Payment Under the DRG Prospective Payment System (Cont'd)

Department's discretion, may take place at the hospital or away from the hospital site.

5) Revision of Coding

A) If the diagnostic and procedural information, attested to by the attending physician, is found to be inconsistent with the hospital's coding, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.

B) If the information attested to by the physician as stipulated under subsection (d)(5)(A) is found not to be consistent with the medical record, the hospital shall be required to provide the appropriate coding and the Department shall recalculate the payment on the basis of the revised coding.

e) Medical Review Requirements: The Department, or its designee, may conduct pre-admission, concurrent, pre-payment, and/or post-payment reviews of:

1) The medical necessity, reasonableness and appropriateness of inpatient hospital admissions and discharges.

2) The quality and/or the nature of the utilization of health services.

3) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of Section 149.105.

4) The validity of the hospital's diagnostic and procedural information.

5) The completeness, adequacy and quality of the services furnished in the hospital.

6) Other medical or other practices with respect to

Section 149.75 ~~Hospital Participation in ICARE Program~~ Negotiations-Conditions for Payment Under the DRG Prospective Payment System (Cont'd)

program participants or billing for services furnished to program participants.

f) Hospitals shall be notified at least thirty (30) days in advance of any pre-admission, concurrent, or pre-payment review requirements imposed by the Department.

g) Denial of Payment as a Result of Admissions, Length of Stay, Transfers and Quality Review

1) If the Department determines that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:

A) Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission or transfer of an individual.

B) Require the hospital to take action necessary to prevent or correct the inappropriate practice.

C) Perform prepayment review in accordance with 89 Ill. Adm. Code 148.240(a).

2) When payment with respect to the discharge of an individual patient is denied by the Department, or its designee, under subsection (f)(1)(A), a reconsideration will be provided within 30 days, upon the request of a practitioner or provider, if such request is the result of the designee's own medical necessity or appropriateness of care

Section 149.75 ~~Hospital Participation in ICARE Program Negotiations~~ Conditions for Payment Under the DRG Prospective Payment System (Cont'd)

denial determination and is received within 60 days of the Advisory Notice. The date of the Advisory Notice is counted as one day.

3) A determination under subsection (f)(1) above, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in actions specified in subsection (a)(2) above.

h) Furnishing of Inpatient Hospital Services Directly or Under Arrangements

1) The applicable payments made under the PPS are payment in full for all inpatient hospital services other than for the services of nonhospital-based physicians to individual program participants and the services of certain hospital-based physicians as described in subsections (g)(1)(B)(i) through (g)(1)(B)(v) below.

A) Hospital-based physicians who may not bill separately on a fee-for-service basis:

i) A physician whose salary is included in the hospital's cost report for direct patient care may not bill separately on a fee-for-service basis.

ii) A teaching physician who provides direct patient care may not bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.

B) Hospital-based physicians who may bill separately on a fee-for-service basis:

i) A physician whose salary is not included in the hospital's cost report for direct patient care may bill separately on a fee-for-service basis.

Section 149.75 ~~Hospital Participation in ICARE Program Negotiations~~ Conditions for Payment Under the DRG Prospective Payment System (Cont'd)

ii) A teaching physician who provides direct patient care may bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.

iii) A resident may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.

iv) A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she may charge for professional services and do, in fact, bill private patients and collect and retain the payments received.

v) A physician holding a nonteaching administrative or staff position in a hospital or medical school may bill separately on a fee-for-service basis to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.

2) Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery,

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Section 149.75 ~~Hospital Participation in ICARE Program Negotiations~~ Conditions for Payment Under the DRG Prospective Payment System (Cont'd)

it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

(Source: Amended at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.100 ~~Negotiation Procedures~~ Basic Methodology for Determining DRG Prospective Payment Rates

~~a) Contract negotiations will be conducted by the Department's Contracting Officer or a person designated in writing by the Contracting Officer to act in his behalf and no more than three (3) representatives of the negotiating hospital or group of hospitals. No more than three Department representatives, including the Contracting Officer or his designee, may be present at any meeting at which negotiations may occur. To assure the confidentiality of the negotiating process and to protect proprietary or confidential or privileged commercial or financial information which is disclosed during negotiations, no individual, corporation, company, partnership, association or other entity may represent at any negotiation session or meeting with the Department more than one negotiating hospital or group of hospitals in any negotiations carried out under the ICARE Program. This subsection does not preclude any such individual, corporation, company, partnership, association or other entity from continuing to represent a hospital or group of hospitals in any renegotiation proceedings concerning such hospital or group of hospitals, nor does it preclude any such individual, corporation, company, partnership, association or other entity from representing more than one hospital in cases where a group of hospitals negotiates to provide inpatient hospital care as a single contracting entity pursuant to 89 Ill. Adm. Code 140.946 or where such representation is performed for more than one hospital where such hospitals are~~

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~~owned by a common owner or managed by the same corporate management service.~~

~~b) The Department will notify of the first meeting date by telephone communication, confirmed by certified or registered mail, return receipt requested, each hospital which has notified the Department of its interest in participation within ten (10) calendar days after receipt of the Department's written notification of the opening of an ICARE area under Section 149.50. The first meeting is designed to familiarize the hospital with the ICARE Program, explain the negotiating and contracting process, respond to questions the hospital or hospitals may have regarding the ICARE Program, and allow the Department negotiator and hospital representative or representatives to become acquainted. Nothing herein shall prevent the institution of preliminary or initial negotiations during the first meeting.~~

~~c) The Department shall provide each hospital, which has notified the Department within ten (10) calendar days of its interest in participation under Section 149.50, with a copy of proposed contract provisions prior to the first meeting by mailing such proposed contract provisions with written notice of the date of the first meeting.~~

~~d) No later than the first meeting date, the hospital or hospitals shall submit to the Department a completed Provider Data Sheet to enable the Department to assure its receipt and examination of the information it must consider under Section 149.105(a). The Department shall furnish with its initial notification to hospitals of intent to open negotiations the form of such Provider Data Sheet. The Provider Data Sheet shall require:~~

~~1) Identification of the types and the quantities of services which the hospital believes to be specialized services that have been provided to recipients during the most recent two completed state fiscal years;~~

~~2) Identification of all types of services intended~~

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to be offered under contract which the hospital has not provided to recipients during the two most recent completed state fiscal years and documentation of the capacity to provide such services by category;

3) Identification of the types and severity of illness of patients treated by the hospital and complexity of care provided by the hospital to patients during the two most recent completed state fiscal years;

4) Financial data which identifies the sources and amounts of direct teaching costs as defined under Medicare and the allocation of a portion of those direct teaching costs to the Medical Assistance Program;

5) Terms of all existing labor management collective bargaining agreements covering hospital employees.

e) After the first meeting and receipt from each hospital of its decision to participate in the ICARE Program as either a member of a group of hospitals or as an individual hospital under Section 149.75(e), the Department shall notify each hospital by certified or registered mail, return receipt requested, of the second meeting date. The purpose of the second meeting is to allow the hospital or group of hospitals to present and interpret terms and price and to identify the representative who has authority to bind the hospital or group of hospitals in the event of subsequent communications and negotiations. The representative who has authority to bind the hospital or group of hospitals shall be present at the second meeting and any subsequent meetings.

f) 1) Prior to conclusion of the second meeting, the hospital or group of hospitals shall have the opportunity to present other material relevant to Section 149.105 that it would like to have considered in the Department's evaluation of its firm and binding offer, and shall submit for negotiating purposes to the Department a firm and binding offer to supply inpatient hospital care

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under the ICARE Program. Such firm and binding offer shall be complete in all respects including rates to be paid by the Department for care rendered under the ICARE Program.

2) Prior to the conclusion of the second meeting, the hospital or group of hospitals shall provide written procedures for the timely admission of recipients being transferred from either a contracting or non contracting hospital. Such procedures shall be reviewed and approved by the Department prior to the execution of an ICARE contract.

g) Written confirmation of the hospital's or group's firm and binding offer submitted at the second meeting and any relevant additional information which was requested by the Department during the first or second meeting must be received by the Department within ten (10) calendar days of the conclusion of the second meeting.

1) The content of the first and second meetings and any subsequent meetings is strictly privileged and confidential and any documents, minutes, data, communications or other similar material and information held by the Department is exempt from the inspection and copying requirements of The Freedom of Information Act (Ill. Rev. Stat. 1987, ch. 116, par. 201 et seq.). The conduct of the first and second meetings and any subsequent meetings and the contents thereof shall not be subject to the provisions of the Open Meetings Act (Ill. Rev. Stat. 1987, ch. 102, par. 41 et seq.).

2) Except as explicitly agreed to by the Department and a hospital or group of hospitals, the contents of all meetings, including the first, second and any subsequent meetings and communications in the course of negotiating and arriving at terms of a contract under the ICARE Program shall be strictly privileged and confidential. In the event that documents, minutes, data, communications or other similar

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~~material and information held by a party to negotiations or to a contract are sought by a third party through administrative process, court order or other similar administrative or judicial mechanisms, the party subject to such attempt shall immediately notify the other party and allow such other party to contest such attempt jointly or of its own accord.~~

~~3) During the first meeting all hospitals shall individually execute for the Department a document in which the hospital shall:~~

~~A) pledge to maintain the confidentiality of the content of all meetings and all communications in the course of negotiating and arriving at contract terms except as thereafter explicitly agreed to by the Department and hospital; and~~

~~B) agree to enforcement of such a pledge through the issuance of a preliminary or permanent injunction or other order by a court of competent jurisdiction in any action brought by the Department for such purpose.~~

~~4) During the first meeting at which a group of hospitals meets with the Department for purposes of negotiating as a single contracting entity, the group's designated representative shall execute for the Department a document in which the hospital shall:~~

~~A) pledge to maintain the confidentiality of the content of all meetings and all communications in the course of negotiating and arriving at contract terms except as thereafter explicitly agreed to by the Department and hospital; and~~

~~B) agree to enforcement of such a pledge through the issuance of a preliminary or permanent injunction or other order by a court of competent jurisdiction in any~~

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~~action brought by the Department for such purpose.~~

~~5) During the course of the first and second meetings and any other subsequent meetings, both the representatives of the Department and the hospital or group of hospitals may take written notes, but no other record keeping by methods such as stenographic transcript or tape recording shall be permitted.~~

~~6) Any contract executed as a result of negotiations under the ICARE Program may be inspected or copied pursuant to the The Freedom of Information Act (Ill. Rev. Stat. 1987, ch. 116, par. 201 et seq.), upon the certification by the Department that all contracts to be negotiated under the ICARE Program in all ICARE areas designated by the Department for contract negotiations have been executed.~~

~~h) The Department, in considering determinations of the Board, shall specify in writing to the Board the points relied upon in any instance in which the Department's conclusion as to the advisability of entering into a contract is contrary to that of the Board. Such written recitation of points is part of the contract negotiating process and, as such, the Board may receive and deliberate upon such written recitation in closed session. Such written recitation is exempt from the inspection and copying requirements of the The Freedom of Information Act (Ill. Rev. Stat. 1987, ch. 116, par. 201 et seq.).~~

~~i) Written determinations both to grant contracts and to the specific provisions in such contracts shall be made by the Department to the Board for each hospital or group of hospitals within an ICARE area no less than 45 days prior to the effective date of the contracts.~~

a) DRG Classification and Weighting Factors

1) DRG Classification. The Department will utilize

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the classification of inpatient hospital discharges by diagnosis related groups (DRGs) as defined by federal regulation for the Medicare Program (42 CFR 412) in effect on September 1, 1991, with modifications deemed appropriate due to the differences in the Medicare and Medicaid patient populations and Illinois Medicaid policy.

2) DRG Weighting Factors

A) Except as provided in subsections (a)(2)(B) through (a)(2)(E) below, the Illinois Medicaid weighting factor for each DRG shall equal the Medicare weighting factor for that group, in effect on September 1, 1991, multiplied by a fraction, the numerator of which is the Medicaid geometric mean length of stay and the denominator of which is the Medicare geometric mean length of stay for that group. In making that calculation, the Department shall:

i) Use the Medicare geometric mean length of stay for each diagnostic-related group as determined by the Health Care Financing Administration of the United States Department of Health and Human Services.

ii) Calculate the Medicaid geometric mean length of stay for each diagnostic-related group using the same methodology employed to calculate the Medicare geometric mean length of stay and using data obtained from the Illinois Health Care Cost Containment Council or the Department's data bases.

B) The Illinois weighting factors for neonatal discharges (Medicare-defined DRGs 385-391 and Illinois-defined DRGs for Level III perinatal centers) shall be the product of the ratio of the mean cost per discharge (defined below) of the given DRG to the mean

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cost per discharge for DRG 391 (normal newborn) and the Medicare scaling factor (defined below), such that the Illinois and Medicare weighting factors for DRG 391 are the same.

i) Mean cost per discharge, for any DRG, is defined as the sum of the product of charges, as reported by a hospital to the Illinois Health Care Cost Containment Council for discharges made during Federal Fiscal Years 1989 and 1990, updated to the current rate year using the DRI factors (defined in 89 Ill. Adm. Code 148.270), and the hospital's cost to charge ratio, as derived from the hospital's base year cost report (e.g., Calendar Year 1989 for Fiscal Year 1992), divided by the number of discharges for that DRG.

ii) Medicare scaling factor is defined as the Medicare weighting factor for DRG 391 (normal newborns).

C) The Illinois weighting factors for psychiatric discharges (DRGs 424-432) shall be computed as specified in subsections (a)(1) and (a)(2) except, prior to computing the Medicaid geometric mean length of stay for those DRGs, all lengths of stay longer than three (3) days are to be set at three (3) days.

D) The Illinois weighting factors for DRGs that will not be paid through the DRG PPS are zero (0.0000). Those include DRG 103, heart transplant; DRG 462, rehabilitation; DRG 480, liver transplant; DRG 481, bone marrow transplant.

E) Except for DRGs otherwise specified in subsections (a)(2)(B) through (a)(2)(D), the Illinois weighting factors for DRGs for

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which available historic discharge data are sparse, fewer than 100 records, shall be computed using an alternate methodology.

i) For those DRGs with 32 or more records available, the Illinois weighting factor shall be set at the midpoint between the weight calculated using the methodology in subsection (a)(2)(A) and the Medicare weighting factor in effect on September 1, 1991.

ii) For those DRGs with fewer than 32 records available, the Illinois weighting factor shall be set equivalent to the Medicare weighting factor in effect on September 1, 1991.

3) Assignment of Discharges to DRGs. The Department will establish a methodology for classifying specific hospital discharges within DRGs which ensures that each hospital discharge is appropriately assigned to a single DRG, based on essential data abstracted from the inpatient bill for that discharge.

A) The classification of a particular discharge will, as appropriate, be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.

B) Each discharge will be assigned to only one DRG (related, except as provided in subsection (a)(3)(C), to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

C) When the discharge data submitted by a hospital show a surgical procedure unrelated

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to a patient's principal diagnosis, the bill will be subject to prepayment review for validation and reverification. The Department's DRG classification system will provide a DRG, and an appropriate weighting factor, for cases for which the unrelated diagnosis and procedure are confirmed.

4) Review of DRG Assignment

A) A hospital has 60 days after the date of the remittance advice indicating initial assignment of a discharge to a DRG to request a review of the assignment. The hospital may submit additional information as a part of its request.

B) The Department shall review the hospital's request and any additional information and decide whether a change in the DRG assignment is appropriate. If the Department decides that a higher-weighted DRG should be assigned, it must request the Department's peer review organization to review the case to verify the change in DRG assignment.

C) Following the 60-day period described in subsection (a)(4)(A) above, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

b) Illinois Rates for Admissions on or after September 1, 1991

1) Interim Reimbursement System. The payments described in Sections 149.5 thru 149.325 and 89 Ill. Adm. Code 148.240 through 148.300 shall be effective for admissions on and after September 1, 1991. In the interim, hospitals shall be reimbursed on a per diem basis for admissions on and after September 1, 1991, as follows:

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A) Hospitals that, on August 31, 1991, have a contract with the Department under Section 3-4 of the Illinois Health Finance Reform Act shall elect to receive interim reimbursement under one of the reimbursement methodologies listed below:

i) The hospital's weighted average contracting rate as stated in the most recently negotiated contract.

ii) The payment methodology in effect August 31, 1991 for non-contracting hospitals in accordance with 89 Ill. Adm. Code 148.220.

B) Hospitals that, on August 31, 1991, do not have a contract with the Department under Section 3-4 of the Illinois Health Finance Reform Act shall continue to be reimbursed based upon the payment methodology in effect August 31, 1991, as outlined in 89 Ill. Adm. Code 148.220.

2) The interim per diem reimbursement system will be replaced by the Medicaid Prospective Payment System no later than April 1, 1992 and appropriate adjustments will be made to adjust payments previously made under the interim per diem reimbursement system. The reimbursement methodologies described in 89 Ill. Adm. Code Part 149 and 148.240 through 148.300 shall be retroactive for admissions on or after September 1, 1991.

3) The payments described in Section 149.125(a)(2) shall be effective on or after July 1, 1991. The payments described in Section 149.125(a)(3) shall be effective on or after August 1, 1991. In the interim, hospitals will continue to receive their disproportionate share reimbursement rate which was in effect on June 30, 1991. Once the Fiscal Year 1992 determination has been made and rates have been calculated for Fiscal Year 1992, appropriate adjustments will be made to the interim disproportionate share rates.

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4) The payments described in 89 Ill. Adm. Code 148.240 through 148.330 shall be effective for services provided on or after September 1, 1991.

5) The payments described in 89 Ill. Adm. Code 148.80 shall be effective for services provided on or after September 1, 1991.

c) Determining Prospective Payment Rates.

1) The Department shall reimburse hospitals for inpatient services at the federal/regional blended rate per discharge for the Medicare Program, which includes the hospital-specific portion as described in subsection (c)(2) below, if applicable, in effect on September 1, 1991, and as computed by the PPS Pricer, Version 10.2, distributed to Medicare intermediaries on January 9, 1991.

2) The hospital-specific portion is defined as the specific status and any applicable add-ons under the Medicare Program in recognition of sole community hospitals, rural referral centers, Medicare dependent hospitals, and rural hospitals deemed urban.

3) The DRG PPS base rate shall be defined as the sum of the amounts computed under subsections (c)(1) and (c)(2), multiplied by the Illinois weighting factor assigned to the DRG into which the case has been classified.

4) In addition to the DRG PPS base rate defined in subsection (c)(3), hospitals shall receive applicable outlier adjustments, in accordance with Section 149.105; per case add-ons for indirect medical education costs, capital costs, direct medical education costs, and CRNA costs in accordance with Section 149.150(c); any applicable add-on for blood clotting factor in

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accordance with Section 149.150(c)(6); applicable adjustments for disproportionate share and uncompensated care in accordance with 89 Ill. Adm. Code 148.120, or if applicable, 148.150; and, on a retrospective basis, any applicable adjustment for kidney acquisition costs in accordance with Section 149.150(c)(5).

d) Application of Upper Payment Limits. The Department shall adjust each of the prospective payment rates determined under subsection (c) above (with the exception of disproportionate share payment adjustments made in accordance with 89 Ill. Adm. Code 148.120) to ensure that aggregate payments do not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles, in compliance with 42 CFR 447.272, Application of Upper Payment Limits.

(Source: Amended at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.105 ~~Factors-Considered-In-Awarding-ICARE-Contracts-~~Payment For Outlier Cases

~~a) The Department shall consider the following factors in negotiating and entering into contracts under the ICARE Program:~~

~~1) whether the price proposed by the prospective Contractor for all types of inpatient hospital care intended to be offered by the Contractor is satisfactory to the Department;~~

~~2) WHETHER THE PROSPECTIVE CONTRACTOR CAN ASSURE ACCESS TO GOOD QUALITY CARE;~~

~~3) WHETHER THERE IS ADEQUATE AVAILABILITY OF GOOD QUALITY SERVICES IN EACH GEOGRAPHIC REGION OF THE STATE TO ENSURE THAT THE NEEDS OF THE RECIPIENTS IN EACH SUCH REGION ARE MET;~~

~~4) WHETHER THE ADEQUATE AVAILABILITY OF GOOD QUALITY SPECIALIZED SERVICES TO MEET THE NEEDS OF~~

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Section 149.105 ~~Factors-Considered-In-Awarding-ICARE-Contracts-~~Payment For Outlier Cases (Cont'd)

~~RECIPIENTS IS ENSURED;~~

~~5) WHETHER DISRUPTIONS TO TRADITIONAL CARE PATTERNS AND TO CONTINUITY OF CARE OF RECIPIENTS WILL BE MINIMIZED;~~

~~6) WHETHER RECOGNITION OF THE VARIATIONS IN SEVERITY OF ILLNESS AND COMPLEXITY OF CARE OF RECIPIENTS BY EACH PROSPECTIVE CONTRACTOR WILL BE MADE AND MONITORED OVER TIME;~~

~~7) WHETHER PROTECTION AGAINST FRAUD AND ABUSE IS ADEQUATELY ENSURED BY THE PROSPECTIVE CONTRACTOR; AND~~

~~8) WHETHER THE PROSPECTIVE CONTRACTOR CAN ENSURE THE PROVISION OF PROPOSED CARE TO RECIPIENTS IN AN ECONOMIC AND EFFICIENT MANNER.~~

~~b) IN NEGOTIATING CONTRACTS, THE DEPARTMENT SHALL CONSIDER EXISTING LABOR MANAGEMENT COLLECTIVE BARGAINING AGREEMENTS COVERING HOSPITAL EMPLOYEES.~~

~~c) IN NEGOTIATING AND ENTERING INTO CONTRACTS THE DEPARTMENT SHALL ENSURE THAT THE TOTAL DOLLAR AMOUNTS OF FUNDS APPROPRIATED FOR MEDICAL ASSISTANCE HOSPITAL INPATIENT CARE IS NOT EXCEEDED BY SUCH CONTRACTS.~~

~~d) DIRECT TEACHING COSTS SHALL BE CONSIDERED A PASS THROUGH FOR CONSIDERING PROPOSALS RECEIVED FROM TEACHING HOSPITALS (all statutory language quoted or paraphrased from Section 3-4 of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1987, ch. 111 1/2, par. 6503-4)).~~

a) General Provisions

1) Basic Rule

A) Except as provided in subsections (a)(1)(B) and (a)(1)(C), the Department provides for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by the Department, to a hospital for covered inpatient hospital services furnished to a Medicaid client, if

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Section 149.105 ~~Factors-Considered-In-Awarding-ICARE-Contracts~~-Payment For Outlier Cases (Cont'd)

either of the following conditions apply:

i) The client's length of stay (including up to three administrative days) exceeds the day outlier threshold, determined by the Department, for the appropriate applicable DRG. The threshold is set at the lesser of the geometric mean length of stay plus 24 days, or the geometric mean length of stay plus three (3) standard deviations.

ii) The hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio, as described in subsection (c)(3), exceed the greater of $29,584, or the hospital's DRG PPS base rate as described in Section 149.100(b)(2)(C) multiplied by two (2).

B) The Department will provide cost outlier payments to a transferring hospital reimbursed under the DRG PPS that does not receive payment under subsection (b) of this Section for discharges specified in Section 149.25(b)(4)(B), if the hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio, as described in subsection (c)(3), exceed the greater of the criteria specified in subsection (a)(1)(A)(ii).

C) The Department will not provide outlier payments for:

i) Discharges classified as psychiatric care (DRGs 424-432). Such care provided by other than hospitals or distinct part units enrolled with the Department to provide psychiatric care (category of service 21) is limited to emergency treatment, to last no longer than three days.

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ii) Discharges assigned to DRGs with an Illinois weighting factor of zero (0.0000).

2) The Department or its designee may review outlier cases on a prepayment or postpayment review basis. The charges for any services identified as noncovered through this review will be denied and any outlier payment having been made for those services will be recovered, as appropriate, after a determination as to the provider's liability has been made. If the Department or its designee finds a pattern of inappropriate utilization by a hospital, all outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the Department or its designee determines that appropriate corrective actions have been taken. The Department, or its designee, must review and approve, to the extent required by the Department:

A) The admission was medically necessary and appropriate.

B) The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay.

C) The services were ordered by the physician, actually furnished, and nonduplicatively billed.

D) The validity of the diagnostic and procedural coding.

E) The granting of up to three administrative (grace) days during which the hospital is seeking an appropriate setting into which to discharge a nonacute patient.

b) Payment for Extended Length-of-Stay Cases (Day Outliers)

1) If the hospital stay includes covered days of care beyond the applicable threshold criterion,

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Section 149.105 ~~Factors Considered In Awarding ICARE Contracts~~ Payment For Outlier Cases (Cont'd)

the Department will make an additional payment, on a per diem basis, to the discharging hospital for those days. A special request or submission is not necessary to initiate this payment.

2) Except as provided in subsections (b)(3) or (d), the per diem payment made under subsection (b)(1) is derived by first taking 60 percent of the per diem payment for the applicable DRG, as calculated by dividing the DRG PPS rate, determined under 89 Ill. Adm. Code 149.100 by the mean length-of-stay for that DRG.

3) The per diem payment made under subsection (b)(1) for burn discharge (DRGs 456-460) is derived under the provisions of subsection (b)(2), except that the calculation is 90 percent of the per diem payment of the applicable DRG.

4) Any days in a covered stay identified as noncovered reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days that occur after the day outlier threshold.

c) Payment for Extraordinarily High Cost Cases (Cost Outliers)

1) If the hospital charges, as adjusted by the method specified in subsection (c)(3) exceed the applicable threshold criterion, the Department will make an additional payment to the discharging hospital to cover those costs. A special request or submission is not necessary to initiate this payment.

2) The Department will reimburse the cost of the discharge on the billed charges for covered inpatient services, adjusted by a cost-to-charge ratio as described in subsection (c)(3).

3) The cost-to-charge ratio used to adjust covered charges is computed annually by the Department for each hospital based on the hospital's base fiscal year (i.e., Calendar Year 1989 for Fiscal Year 1992 payments) and charge data for UB-82

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Section 149.105 ~~Factors Considered In Awarding ICARE Contracts~~ Payment For Outlier Cases (Cont'd)

Uniform Billing Forms for all claims for inpatient services provided to Medicaid recipients in the previous state fiscal year which have been paid by the Department. Statewide cost-to-charge ratios are used in those instances in which a hospital's cost-to-charge ratio falls outside reasonable parameters or cannot be computed due to a lack of information (e.g., a new hospital for which the Department is not in possession of the required historical information).

4) If any of the services are determined to be noncovered, the charges for those services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.

5) Except as provided in subsection (c)(6), the additional amount is 75 percent of the difference between the hospital's adjusted cost for the discharge (as determined under subsection (c)(3)) and the threshold criteria established under subsection (a)(1)(A)(ii).

6) The additional payment amount for burn cases (DRGs 456-460) is computed under the provisions of subsection (c)(5), except that the payment is 90 percent of the difference between the hospital's adjusted cost for the discharge and the threshold criteria.

d) Payment for Extraordinarily High Cost Day Outliers. If a discharge qualifies for an additional payment under the provisions of both subsections (b) and (c), the additional payment is the greater of the following:

1) The payment computed under subsection (b) above.

2) The payment computed under subsection (c) above.

(Source: Amended at 16 Ill. Reg. 6195, effective March 27, 1992)

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Section 149.125 ~~Closing an ICARE Area~~ Special Treatment of Certain Facilities

~~a) The Department shall designate an ICARE area "closed" to negotiations when the Department has negotiated contracts which have become effective with hospitals for the total aggregate number of inpatient days necessary to meet the needs of recipients who historically have received inpatient hospital care in that ICARE area, or who the Department expects will receive inpatient hospital care in that ICARE area. After an ICARE area is closed, the Department will further ensure the availability of care by invoking the travel standard exception delineated in Section 149.205(d) if the need for a particular type of care arises.~~

~~b) The Department shall notify all medical providers of the names and locations of hospitals providing services under contracts with the Department through the ICARE Program, including the types of specialized services available at hospitals. Notice will be provided at least 45 days prior to the closure of an ICARE area.~~

~~c) The Department shall notify all recipients of the names and location of hospitals providing services under contracts with the Department through the ICARE Program, including the types of specialized services available at hospitals. Notice will be provided prior to the closure of an ICARE area.~~

a) General Rules

1) Sole Community Hospitals. Hospitals defined as sole community hospitals shall, under subsection (b), have the choice of being reimbursed under the DRG PPS methodology, as described in Sections 149.25 through 149.105 and 149.150, or the Department's Alternate Reimbursement methodology as described in 89 Ill. Adm. Code 148.240 through 148.300.

2) Hospitals that Serve a Disproportionate Share of Low Income Patients. The Department shall make additional payments to hospitals that serve a disproportionate share of low income patients. The criteria and methodologies for such additional payments are set forth in 89 Ill. Adm.

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Section 149.125 ~~Closing an ICARE Area~~ Special Treatment of Certain Facilities (Cont'd)

Code 148.120 and include applicable additional payments for targeted access care, critical access care and uncompensated care.

3) Uncompensated Care Adjustments for Nondisproportionate Share Hospitals. The Department shall make an additional payment to nondisproportionate share hospitals that provide equal access to low income persons. The criteria and methodology for this additional payment are set forth in 89 Ill. Adm. Code 148.150.

b) Criteria for Classification as a Sole Community Hospital. "Medicaid Sole Community Provider" means a hospital that meets one of the following criteria:

1) Any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program; or

2) Any hospital located outside of a metropolitan statistical area that serves 55 percent or more of the Medicaid patients residing within the hospital's primary service area. "Primary service area" means the geographic area defined by U.S. Postal Service Zip Codes in which 50 percent or more of a hospital's inpatients reside.

(Source: Amended at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.150 ~~Administrative Review~~ Payments to Hospitals Under the DRG Prospective Payment System

~~a) If the Hospital Services Procurement Advisory Board recommends that a hospital or group of hospitals enter into a contract with the Department and the Department rejects the Board's recommendation, the affected hospital or group of hospitals shall have the right to seek review of the Department's decision in accordance with the Administrative Review Law (Ill. Rev. Stat. 1983, ch. 110, par. 3-101 et seq.).~~

~~b) In all cases in which a party is aggrieved by the~~

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Section 149.150 ~~Administrative Review~~ Payments to Hospitals Under the DRG Prospective Payment System (Cont'd)

~~final action of the Department under the ICARE Program, the party shall have the right to seek review of the Department's action in accordance with the Administrative Review Law.~~

a) Total Medicaid Payment. Under the DRG PPS, the total payment for inpatient hospital services furnished to a Medicaid client by a hospital will equal the sum of the payments listed in subsections (b) through (c). In addition to the payments listed in subsections (b) through (c) of this Section, hospitals shall also receive applicable disproportionate share adjustments in accordance with 89 Ill. Adm. Code 148.120, if applicable, and uncompensated care adjustments in accordance with 89 Ill. Adm. Code 148.150, if applicable.

b) Payments Determined on a Per Case Basis. A hospital will be paid on a per case basis (with the exception of kidney acquisition costs and blood clotting factor costs) the following amounts:

1) the appropriate DRG PPS rate for each discharge as determined in accordance with Section 149.100(b)(2).

2) The appropriate outlier payment amounts determined under Section 149.105.

3) Capital related costs as determined under subsection (c)(1) below.

4) Direct medical education costs as determined under subsection (c)(2) below.

5) Indirect medical education costs as determined under subsection (c)(3) below.

6) Anesthesia services of hospital employed nonphysician anesthetists (Certified Registered Nurse Anesthetists or "CRNAs") as set forth in Section 6132(a) of the Omnibus Budget Reconciliation Act of 1989 and in accordance with subsection (c)(4).

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Section 149.150 ~~Administrative Review~~ Payments to Hospitals Under the DRG Prospective Payment System (Cont'd)

7) Kidney Acquisition Costs in accordance with subsection (c)(5).

8) Blood Clotting Factor Administered to Hemophilia Inpatients in accordance with subsection (c)(6).

c) Payments for Capital, Direct Medical Education, Indirect Medical Education, CRNA, Kidney Acquisition and Hemophilia Inpatient Blood Clotting Factor Costs. These costs shall be paid on a per case basis, with the exception of kidney acquisition costs and blood clotting factor costs, and shall be calculated as follows:

1) Capital Related Costs

A) The capital related cost per diem shall be calculated by taking the hospital's total capital related costs as reported on the hospital's latest audited Medicare cost report on file with the Department, (i.e., two hospital report years, 1988 and 1989, are used for FY'92 rates, 1989 and 1990 for FY'93, etc.) divided by the hospital's total inpatient days, trended forward to the midpoint of the current rate year using the national total hospital market basket price proxies (DRI).

B) These two trended capital related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.

C) The adjusted capital related cost per diem amount, as calculated in subsection (c)(1)(B) above, shall be rank ordered for all hospitals and capped at the 80th percentile.

D) Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in subsection (c)(1)(B) or subsection (c)(1)(C)

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above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.

2) Direct Medical Education Costs

A) The direct medical education cost per case shall be calculated by taking the hospital's total direct medical education costs as reported on the hospital's latest audited Medicare cost report on file with the Department, (i.e., two hospital report years, 1988 and 1989, are used for FY'92 rates, 1989 and 1990 for FY'93, etc.) divided by the hospital's total inpatient days, trended forward to the midpoint of the current rate year using the national total hospital market basket price proxies (DRI).

B) These two trended direct medical education costs per diems are then added together and divided by two to calculate the hospital's adjusted direct medical education cost per diem.

C) The adjusted direct medical education cost per diem amount, as calculated in subsection (c)(2)(B) above, shall be rank ordered for all hospitals reporting such costs and capped at the 80th percentile.

D) Each hospital shall receive a per case add-on for direct medical education costs which shall be equal to the amount calculated in subsection (c)(2)(B) or subsection (c)(2)(C) above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.

3) Determination of Indirect Medical Education Adjustment Factor. To determine the indirect medical education factor, the Department shall use the indirect medical education factors as

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Section 149.150 ~~Administrative Review~~ Payments to Hospitals Under the DRG Prospective Payment System (Cont'd)

determined by HCFA and found in the DRG Pricer, Version 10.2. This factor shall be multiplied by the sum of the result of the calculation described in Section 149.100(c)(3) plus any applicable outlier payments as described in Section 149.105.

4) CRNA Costs

A) Only hospitals that qualify for these payments under the Medicare Program (Section 5261 of HCFA 14-3 Update, 3-1-91) shall be eligible for these payments.

B) The CRNA cost per case amount shall be calculated by taking the hospital's total CRNA costs (as reported on the hospital's latest audited Medicare cost report on file with the Department, (i.e., hospital report year 1989 is used for FY'92 rates, 1990 for FY'93, etc.) divided by the hospital's total inpatient days, trended forward to the midpoint of the current rate year using the national total hospital market basket price proxies (DRI).

C) Each qualifying hospital, as described in subsection (c)(4)(A) above, shall receive a per case add-on for CRNA costs which shall be equal to the amount calculated under subsection (c)(4)(B) above, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.

5) Kidney Acquisition Costs. Kidney Acquisition Costs shall be reimbursed on a retrospective basis. The reimbursement shall be calculated by multiplying the hospital's total charges for the kidney acquisition by the hospital's cost-to-charge ratio as described in Section 149.105 (c)(3).

6) Payment for Blood Clotting Factor Administered to Hemophilia Inpatients.

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Section 149.150 ~~Administrative Review~~ Payments to Hospitals Under the DRG Prospective Payment System (Cont'd)

A) The blood clotting factor adjustment shall be based upon a predetermined price per international unit (IU) of blood clotting factor (as determined under the Medicare Program effective September 1, 1991) multiplied by the number of units provided.

B) Three separate adjustment amounts shall be made, one for each of the three basic types of clotting factor (Factor VIII, Factor IX and other factors which are given to the patients with inhibitors to Factors VIII and IX). The adjustment amounts for the three types of blood clotting factor per unit are:

i) Factor VIII, viral inactivated, $ .64 per IU

ii) Factor IX, complex, heat-treated, $ .26 per IU

iii) Other hemophilia clotting factors (e.g., anti-clotting inhibitors), $1.00 per IU

d) Method of Payment

1) General Rule. Unless the provisions of subsection (d)(2) apply, hospitals are paid for each discharge based on the submission of a discharge bill. Payments for inpatient hospital services furnished by an excluded distinct part psychiatric or a rehabilitation unit of a hospital are made in accordance with 89 Ill. Adm. Code 148.270(b).

2) Special Interim Payment for Unusually Long Lengths of Stay

A) First Interim Payment. A hospital may request an interim payment after a Medicaid client has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final

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discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

B) Additional Interim Payments. A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under subsection (d)(2)(A). Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of subsection (d)(2).

3) Outlier Payments. Except as provided in subsection (d)(2), payment for outlier cases (described in Section 149.105) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.

e) Reductions to Total Payments

1) Copayments. Copayments are assessed under all medical programs administered by the Department and shall be assessed in accordance with 89 Ill. Adm. Code 148.190.

2) Third Party Payments. Hospitals shall determine that services rendered are not covered, in whole or in part, under any other state or federal medical care program or under any other private group indemnification or insurance program, health maintenance organization, preferred provider organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.

f) Effect of Change of Ownership on Payments Under the DRG Prospective Payment System. When a hospital's ownership changes, the following rule applies:

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Section 149.150 Administrative Review Payments to Hospitals Under the DRG Prospective Payment System (Cont'd)

Payment for the cost of inpatient hospital services for each patient, including outlier payments, as provided under subsection (b) above, will be made to the entity that is the legal owner on the date of discharge. Payments will not be prorated between the buyer and seller.

1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a Medicaid client regardless of when the client's coverage began or ended during a stay, or of how long the stay lasted.

2) Each bill submitted must include all information necessary for the Department to compute the payment amount, whether or not some of the information is attributable to a period during which a different party legally owned the hospital.

(Source: Amended at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.175 Payments to Contracting Hospitals (Repealed)

a) ~~Payment rates will be specified within each hospital's or group of hospitals' contract. CONTRACTS UNDER THE IGARE PROGRAM MAY PROVIDE FOR DIFFERENT PAYMENTS TO HOSPITALS FOR THE SAME SERVICE OR CARE. THE DEPARTMENT MAY CONTRACT FOR A VARIABLE RATE RELATED TO DIFFERENT VOLUMES OF SERVICE OR CARE. THE DEPARTMENT CAN VARY RATES FOR EACH INCREMENTAL INCREASE IN SERVICE OR CARE LEVELS. (Ill. Rev. Stat. 1984 Supp., ch. 111 1/2, par. 6503-4). The Department may vary rates within an IGARE area or between IGARE areas.~~

b) ~~Payment rates will be paid by the Department as specified in each hospital's or group of hospitals' contract for inpatient hospital care provided on or after the effective date of the contract.~~

c) ~~Contracting hospitals or groups of hospitals will be paid by the Department in accordance with the payment methodology specified in 89 Ill. Adm. Code 140.361 through 140.375 for inpatient hospital care rendered prior to the effective date of the contract.~~

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Section 149.175 Payments to Contracting Hospitals (Repealed) (Cont'd)

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.200 Admitting and Clinical Privileges (Repealed)

a) ~~IN ORDER THAT RECIPIENT FREEDOM OF CHOICE AS TO A LICENSED PHYSICIAN MAY CONTINUE, TO THE EXTENT POSSIBLE, TO BE A VITAL ELEMENT OF THE PROVISION OF INPATIENT HOSPITAL CARE, EACH HOSPITAL ENTERING A CONTRACT UNDER THE IGARE PROGRAM AS A SINGLE HOSPITAL OR AS A MEMBER OF A GROUP OF HOSPITALS MUST COVENANT IN WRITING THAT IT SHALL GRANT ADMITTING AND CLINICAL PRIVILEGES TO ALL QUALIFIED PRACTITIONERS WHO SEEK SUCH PRIVILEGES FOR PURPOSES OF TREATING MEDICAL ASSISTANCE PATIENTS, AND WHO MEET THE REASONABLE STANDARDS AND CRITERIA ESTABLISHED BY THE HOSPITAL FOR THE GRANTING OF SUCH PRIVILEGES, AND THAT APPLICATIONS SHALL BE CONSIDERED AND PROCESSED WITHOUT PREJUDICE AND UNDER THE SAME PROCESS AND WITH AT LEAST THE SAME DEGREE OF TIMELINESS AS APPLICATIONS OF PRACTITIONERS TREATING PRIVATE PATIENTS AT THE HOSPITAL. THE DEPARTMENT SHALL MONITOR EACH CONTRACTING HOSPITAL TO ENSURE ITS COMPLIANCE WITH SUCH COVENANTS AND OBLIGATIONS. (Ill. Rev. Stat. 1984 Supp., ch. 111 1/2, par. 6503-4).~~

b) ~~To assist the Department in monitoring compliance with such covenants and obligations, each hospital prior to entering into any contract under the IGARE Program as a single hospital or as a member of a contracting group of hospitals shall provide the Department:~~

1) ~~those provisions of its policies and medical staff bylaws, rules and regulations governing the credentialing of its medical staff; and any additions, changes or amendments thereto adopted prior to the close of contract negotiations with the hospital or group of hospitals; and~~

2) ~~a statement specifying the period of time typically used in reviewing an applicant for privileges and granting privileges once a~~

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Section 149.200 Admitting and Clinical Privileges (Repealed) (Cont'd)

finalized application and all supporting materials have been submitted by an applicant and verified by the hospital that they are accurate and complete, and references necessary to appraise the applicant have been received by the hospital; any delays currently encountered by the hospital in performing background and reference checks and medical staff review of completed applications due to backlogs caused by currently pending applications; any further delays in such steps anticipated by the hospital due to an increased volume of applications in the event the hospital becomes a contracting hospital or a member of a contracting group of hospitals, and the hospital's plans for relieving such delays and backlogs.

e) Each contracting hospital and each member of a contracting group of hospitals shall submit to the Department any additions, changes or amendments to the credentialing provisions of its policies and medical staff bylaws, rules and regulations adopted subsequent to the award of a contract by the Department.

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.205 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Repealed)

a) Payment will be made for the following inpatient hospital care or services provided to recipients by non-contracting hospitals based upon review of necessity:

b) "True emergency services" which are inpatient hospital care or services provided for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries which might result in disability or death without immediate treatment documented by the recipient's admission sheet, discharge abstract or summary, and physician progress notes. Hospitals seeking payment for the provision of true emergency services shall submit such

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Section 149.205 Inpatient Hospital Care or Services by Non-Contracting Hospitals Eligible for Payment (Repealed) (Cont'd)

documentation to the Department prior to the submission of the claim for payment.

c) "Medicare crossover services" which are inpatient hospital care or SERVICES PROVIDED TO RECIPIENTS WHEN A PORTION OF THE PAYMENT FOR SUCH SERVICES IS BEING MADE UNDER PART A OF THE MEDICARE PROGRAM (42 CFR 405, Subpart A (1984)) (statutory language from Ill. Rev. Stat. 1984 Supp., ch. 111 1/2, par. 6503-4).

d) "Services provided upon reasonable recipient travel" means inpatient hospital care or SERVICES PROVIDED TO RECIPIENTS WHO LIVE OR RESIDE FARTHER THAN THE REASONABLE TRAVEL STANDARD AS DEFINED BY THE DEPARTMENT (see Table C) (Ill. Rev. Stat. 1984 Supp., ch. 111 1/2, par. 6503-4) for the community in which they live or reside, from either:

1) a contracting hospital or a member of a contracting group of hospitals; or

2) any hospital participating in the Medical Assistance Program in an ICARE area which has not been closed, if the non-contracting hospital providing the care is closer to where they live or reside than either a contracting hospital or a hospital participating in the Medical Assistance Program located in an ICARE area not closed.

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.225 Payment to Hospitals for Inpatient Services or Care not Provided under the ICARE Program (Repealed)

Payment to non-contracting hospitals for eligible services, to hospitals not located in an ICARE area, and to hospitals which are in an ICARE area which is not closed will be based upon the payment methodology stated in 89 Ill. Adm. Code 140.361 through 140.375.

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

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Section 149.250 Contract Monitoring (Repealed)

a) ALL UTILIZATION CONTROLS APPLIED TO INPATIENT HOSPITAL CARE BY THE DEPARTMENT IN ACCORDANCE WITH THE APPROVED PLAN FOR MEDICAL SERVICES UNDER SECTION 5-2 OF THE ILLINOIS PUBLIC AID CODE (ILL. REV. STAT. 1983, CH. 23, PAR. 5-2), AND TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT (42 U.S.C. 1396a) SHALL CONTINUE TO APPLY TO INPATIENT HOSPITAL CARE PROVIDED UNDER THE ICARE PROGRAM. (Ill. Rev. Stat. 1984 Supp., ch. 111 1/2 par. 6503-5).

b) THE DEPARTMENT SHALL PROVIDE FOR A PROGRAM OF DELEGATED UTILIZATION REVIEW AND QUALITY ASSURANCE. HOSPITALS PROVIDING INPATIENT HOSPITAL CARE UNDER THE ICARE PROGRAM MAY ELECT TO VOLUNTARILY FORGO THE DELEGATED STATUS. THE DEPARTMENT MAY CONTRACT WITH MEDICAL PEER REVIEW ORGANIZATIONS PROVIDED THAT AT LEAST TEN (10) PERCENT OF THE ORGANIZATION IS COMPOSED OF AREA PHYSICIANS to provide utilization review and quality assurance under any contract negotiated for inpatient hospital care provided under the ICARE Program. THE DEPARTMENT SHALL REQUIRE PRIOR APPROVAL FOR HOSPITAL PLACEMENTS WHERE THERE IS A LIKELIHOOD THAT THE PLACEMENT WILL RESULT IN UNNECESSARY UTILIZATION OF HIGH PRICED INPATIENT HOSPITAL CARE. (Ill. Rev. Stat. 1984 Supp., ch. 111 1/2, par. 6503-5). Such care will also be subject to post care review.

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.275 Transfer of Recipients (Repealed)

a) On or after the date of designation of closure of an ICARE area under Section 149.125, transfer of recipients from a non contracting hospital to a contracting hospital or a member of a contracting group of hospitals must occur prior to admission unless the recipient's condition requires true emergency services, as defined by Section 149.205. For hospitals becoming non contracting by virtue of exhausting the days allowed under an ICARE contract, payment for up to five days after a determination has been made that the recipient's condition no longer requires such true emergency services shall be at the ICARE rate, and all additional days of care at 80

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Section 149.275 Transfer of Recipients (Repealed) (Cont'd)

percent of the ICARE rate. For hospitals becoming non contracting by virtue not receiving an ICARE contract upon closure of an ICARE area, payment for up to five days after a determination has been made that the recipient's condition no longer requires such true emergency services shall be at the per diem rate, and all additional days of care at 80 percent of the per diem rate as defined by 89 Ill. Adm. Code 140.360. Payments in both such cases will only be made after the Department's designated peer review organization has reviewed claims submitted and certified that the admission resulted in the provision of true emergency services as defined by the Department. Payment will not be made for medically unnecessary days as determined by the Department or its designee.

b) Transfer of recipients from one contracting hospital to another contracting hospital requires prior approval of the Department except when the recipient's level of care requires immediate attention which is not available at the first location or there is no bed capacity within the first hospital. The Department must be notified by the receiving hospital within two (2) business days that such a transfer has occured. Documentation of the necessity for such transfers must be available for review by the Department, or its designee.

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.300 Validity of Contracts (Repealed)

Any contract negotiated in substantial compliance with the terms of P.A. 83-1243 and rules and regulations promulgated thereunder is valid and of full force and effect and shall only be deemed void and of no effect upon a final judicial finding, of which appeals have been exhausted, that such contract was not negotiated in substantial compliance with P.A. 83-1243 and rules and regulations promulgated thereunder. Nothing herein excuses or allows waiver of the provisions contained in Section 140.946 relating to the time and manner in which hospitals or groups of hospitals must advise the Department of a decision to

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Section 149.300 Validity of Contracts (Repealed) (Cont'd)

~~participate in the ICARE Program.~~

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.305 Termination of ICARE Contracts (Repealed)

~~a) All contracts entered into between the Department and a hospital participating in the ICARE Program will have a uniform termination date by contract area. The date of termination and the date on which new contracts will be negotiated and effective in each contract area for those hospitals that entered into a contract prior to July 1, 1986 will be no later than 27 months from the initial effective date of the contracts negotiated by the Department during the initial round of negotiations in each contract area. All contracts resulting from negotiations subsequent to July 1, 1986, will have a term of 24 months subject to the uniform termination date for all contracts in a contract area.~~

~~b) Hospitals or groups of hospitals which have contracts with the Department for the provision of inpatient hospital care in the ICARE program with a uniform termination date pursuant to Section 147.305(a) on a date other than the last day of the State's fiscal year (i.e., June 30) such that the ICARE contract is in effect for part of a State fiscal year and which have been awarded general or specialized care days (as defined in each ICARE contract) on a State fiscal year basis shall be reimbursed as follows:~~

~~1) The maximum number of days of general or specialized care awarded for a State fiscal year pursuant to an ICARE contract shall be prorated to the portion of the State fiscal year that the ICARE contract will be in effect based on the number of calendar days that will elapse from July 1 to the termination date of the ICARE contract to the total calendar days in the State fiscal year.~~

~~2) The hospital will be reimbursed up to the maximum of the prorated days established in Section 147.305(b)(1) multiplied by 110%. This product~~

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Section 149.305 Termination of ICARE Contracts (Repealed) (Cont'd)

~~shall be the hospital's contract maximum for the partial State fiscal year.~~

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

Section 149.325 Hospital Services Procurement Advisory Board (Repealed)

~~a) Pursuant to P.A. 83-1243, there is created a Hospital Services Procurement Advisory Board whose responsibility shall be to advise the Department of the reasonableness of contracts into which the Department enters with appropriate individual hospitals or groups of hospitals for the provision of inpatient hospital care to recipients of Medical assistance other than those recipients under the prepaid capitated full service program of the Department or those who are eligible to receive Part A benefits under Medicare.~~

~~b) The Board may hold closed sessions for the purpose of reviewing proposed contracts with hospitals for the provision of inpatient hospital care to recipients and receiving and deliberating upon written specific points relied upon by the Department in situations where the Department's conclusion as to the advisability of entering into a contract is contrary to that of the Board.~~

(Source: Repealed at 16 Ill. Reg. 6195, effective March 27, 1992)

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NOTICE OF ADOPTED AMENDMENTS

1) The Heading of the Part: HOSPITAL SERVICES

2) Code Citation: 89 Ill. Adm. Code 148

3) Section Numbers: Adopted Action:

148.20	Amendment
148.40	Amendment
148.60	Amendment
148.70	Amendment
148.80	Amendment
148.90	Repealed
148.100	Repealed
148.110	Repealed
148.120	Amendment
148.130	Amendment
148.140	Amendment
148.150	Amendment
148.160	Amendment
148.170	Amendment
148.180	Amendment
148.190	Amendment
148.200	Amendment
148.210	Amendment
148.220	Amendment
148.230	Amendment
148.240	Amendment
148.250	Amendment
148.260	Amendment
148.270	Amendment
148.280	Amendment
148.290	Amendment
148.300	Amendment
148.310	Amendment
148.320	Amendment
148.400	New Section

4) Statutory Authority: Sections 5-5.1 et seq. and 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, Ch. 23, Pars. 5-5.1 et seq. and 12-13)

5) Effective Date of Adopted Amendments: March 27, 1992

6) Does this rulemaking contain an automatic repeal date?
___Yes _X_No

7) Do these Adopted Amendments contain incorporations by reference? No

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8) Date Filed in Agency's Principal Office: March 27, 1992

9) Notice of Proposal Published in Illinois Register:

November 8, 1991 (15 Ill. Reg. 15928)

10) Has JCAR issued a Statement of Objections to these Adopted Amendments? No

11) Differences between proposal and final version:

Section 148.40

Subsection (a) - delete "." after "Services"; starting with "To" starts a new paragraph.

Subsection (a)(1) - add "Federal Medicaid regulations preclude payment for patients over the age of 20 or under the age of 65 in any Institution for Mental Diseases (IMD). Therefore, psychiatric hospitals may not receive reimbursement for services provided to patients over the age of 20 or under the age of 65." after "and is enrolled with the Department as, a psychiatric hospital."; correct spelling of "provide" from "proivde".

Subsection (a)(2)(B) - delete "State's" before "authorized"; add "in the state in which the hospital is located" after "licensing agency".

Subsection (b)(2) - add "1991," after "Stat."; decapitalize "Ch."; decapitalize "Par.".

Subsection (b)(3)(A) - delete "Part".

Subsection (b)(3)(B) - delete "Section".

Subsection (c)(1) - delete "The"; capitalize "hospital"; also add "s" to "Hospital"; delete "," after "above".

Section 148.80

Subsection (b)(2) - add "Centers must complete the certification process established in Section 148.80(c) and provide the necessary documentation of the number of transplant procedures performed and the survival rates." at the end of this subsection.

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Subsection (c)(1)(D) - add "on each patient for the type of transplant for which the hospital is seeking certification"; delete "for all transplants"; replace "outcome summaries" with "patient-specific transplant outcome".

Subsection (d)(1)(D) - changed "fifteen" in both places to "twelve"; add "for adult heart and liver transplants and for adult and pediatric bone marrow transplants" at the end of this subsection.

Subsection (d)(1) - add new subsection (E) which reads as follows "A hospital specializing in pediatric hear and/or liver transplants must have a program in operation for at least three years and must have performed a minimum of six transplant procedures per year for the past two years, and six before that;"; reletter existing subsections accordingly.

Subsection (d)(1)(M) - add "as supported by the Kaplan-Meier method or other method accepted by the Department" at the end of this subsection; change ";" to ":".

Subsection (d)(1)(M)(i) - change "." to ";".

Subsection (d)(1)(M)(ii) - change "." to ";".

Subsection (d)(2) - delete "," after "space"; add "and" after "space".

Subsection (d)(3) - replace "; and" with ".".

Subsection (e)(1) - change "sections" to "subsections".

Subsection (e)(2) - add "The center must maintain patient volume in the year of certification based on previous transplant statistics." at the end of this subsection.

Subsection (g) - capitalize "section".

Subsection (g)(1) - delete "," after "and".

Subsection (g)(2) - delete "," after "or".

Subsection (g)(3) - delete "," after "or".

Subsection (g)(4) - delete "," after "or".

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Subsection (g) - add new paragraph between last two paragraphs in this subsection: "Applicable disproportionate share payment adjustment shall be made in accordance with 89 Ill. Adm. Code 148.120(g). Applicable outlier adjustments shall be made in accordance with 89 Ill. Adm. Code 148.130(d)."

Subsection (g) - last paragraph: add "," after "140.492".

Section 148.120

Subsection (a)(5)(A) - decapitalize "State".

Subsection (a)(5)(E) - add "a" before "rural".

Subsection (c)(2) - change "30th" to "30"; capitalize "state".

Subsection (c)(3)(B) - decapitalize "State".

Subsection (f) - capitalize "state".

Subsection (g)(2)(B) - add "and those reimbursed under 89 Ill. Adm. Code 148.80(g)" after "basis"; add "The adjustment calculated under this subsection shall be applied to each covered day of care provided." at the end of this subsection.

Subsection (j)(1) - change "and" to "or" after "Part 149".

Subsection (j)(2)(B)(ii) - delete "provided" after "admissions".

Subsection (k)(2)(A) - change "$4,800.00" to "$9,600.00".

Subsection (k)(2)(B) - change "$4,700.00" to "$9,400.00".

Subsection (k)(2)(C) - change "$4,700.00" to "$9,400.00".

Susection (l)(2) - replace "sent to" with "received by".

Subsection (l)(4) - replace "December 1, 1991" with "January 15, 1992".

Subsection (l)(6) - delete "certified financial"; add "certifying to the accuracy of the data submitted" after "officer".

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Subsection (1)(7) - add "required to submit cost reports in accordance with 89 Ill. Adm. Code 148.210(a)" after "hospitals"; change "which" to "that" before "provided".

Subsection (1)(8) - add "and thereafter," after "August 1, 1992,"; add "and in subsequent uncompensated care rate years" before "shall,"; add "Factors which the Department may consider in determining whether a significant decrease in uncompensated care has occurred may include, but not be limited to, a change in socio-economic characteristics of the community." at the end of this subsection.

Subsection (1)(10) - add "Nothing in this subsection shall be construed to imply that a hospital that is ineligible for an uncompensated care payment adjustment has not met the requirements of Section 5-17 of the Public Aid Code." at the end of this subsection.

Section 148.130

Add subsection (c) which was omitted.

Subsection (d) - add "or hospitals reimbursed in accordance with 89 Ill. Adm. Code 148.80(g)" at the end of this subsection.

Subsection (d)(2)(A) - delete "Section".

Subsection (d)(2)(B) - delete "Section".

Subsection (f)(2) - add "for services provided prior to July 1, 1991 and for services provided July 1, 1991 and after in non-disproportionate share hospitals and for individuals under the age of six for services provided July 1, 1991 and after in a disproportionate share hospital" after "one".

Subsection (f)(3) - changed "of" to "to"; changed the first "1988" to "1987".

Section 148.140

Subsection (a)(3) - replace entire language with new language:

Add new subsection (a)(4).

Renumber existing subsection (a)(4) to (a)(5).

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Subsection (c) - change "1990" to "1991".

Subsection (c)(3) - add "effective 9/1/91, an Illinois" before "state-owned"; change "hospitallocated" to read as "hospital located".

Section 148.150

Subsection (b) - replace "sent to" with "received by".

Subsection (d) - replace "December 1, 1991" with "January 15, 1992".

Subsection (f) - delete "certified financial"; add "certifying to the accuracy of the data submitted" after "officer".

Subsection (g) - add "required to submit cost reports in accordance with 89 Ill. Adm. Code 148.210(a) that" after "hospitals"; delete "which" before "provided".

Subsection (h) - add "and in subsequent uncompensated care rate years" before "shall,"; add "Factors which the Department may consider in determining whether a significant decrease in uncompensated care has occurred may include, but not be limited to, a change in socio-economic characteristics of the community." at the end of this subsection.

Subsection (j) - add "Nothing in this subsection shall be construed to imply that a hospital that is ineligible for an uncompensated care payment adjustment has not met the requirements of Section 5-17 of the Public Aid Code." at the end of this subsection.

Section 148.160

Subsection (c) - add "Restructing Adjustment" then start new paragraph with "Adjustments to base..."; delete "Data Resources, Inc. (DRI)"; add "to the hospital" after "national"; add "Data Resources, Inc. (DRI)" after "proxies"; delete "hospital inpatient general routing operating costs,".

Subsection (f)(2) - change "sumo" to "sum"; change "plu" to "plus".

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Section 148.170

Subsection (c) - delete "Data Resources, Inc. (DRI)"; add "to the hospital" after "national"; add "Data Resources, Inc. (DRI)" after "proxies"; delete "hospial inpatient general routing operating cost,".

Section 148.190

Subsection (b) - add "except the General Assistance Medical Program" after "Department".

Section 148.210

Subsection (a) - delete "or more".

add new subsection (d).

Section 148.240

Subsection (b) - replace entire language with new language.

Section 148.260

Subsection (b) - change "operation" to "operating".

Section 148.270

Subsection (b) - add "In the case of a new distinct part unit for which the Department has insufficient paid claims history data available, the Department shall utilize the average payment rate calculated under this subsection (b) for like distinct part units." at the end of this subsection.

Subsection (c) - add "a new hospital (not previously owned or operated), a hospital that has significantly changed its case-mix profile (e.g. a general acute care hospital changing its case-mix to reflect a predominance of long term care patients), or" after "the case of".

Subsection (c)(1) - add "in the aggregate" after "shall be"; delete "148.280(b) and".

Subsection (c)(2) - change "149.150(c)(1)" to "149.50(c)(1)".

Subsection (c)(3) - change "149.150(c)(2)" to "149.50(c)(2)".

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Subsection (c)(4) - change "149.150(c)(4)" to "149.50(c)(4)".

Section 148.310

Subsection (a)(2) - change "audit" to "audited"; delete "Disproportionate share determination reviews shall be limited to the following:".

Subsection (b) - add new paragraph before subsection (b)(1): "Disproportionate share determination reviews shall be limited to the following:"

Section 148.400

add "Information submitted will remain confidential." at the end of this Section.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will these Adopted Amendments replace Emergency Amendments currently in effect? Yes

14) Are there any Amendments pending on this Part? Yes

Section Number	Proposed Action	Illinois Register Citation
148.140	Amendment	January 31, 1992 (16 Ill. Reg. 1786)

15) Summary and Purpose of Adopted Amendments: This rulemaking describes several new reimbursement methodologies for hospitals (Numbers in parentheses indicate the estimated increase resulting from the particular component to the Department's aggregate expenditures to hospitals for Fiscal Year 1992): reimbursement for county-owned and state-owned hospitals in counties with populations over 3 million ($450 million); disproportionate share hospitals (including additional adjustments for targeted access and critical care access hospitals ($18 million); outpatient hospital reimbursement ($20 million); uncompensated care reimbursement methodologies ($65 million); and alternate reimbursement methodologies for hospitals excluded from the Diagnosis Related Grouping Prospective Payment System (DGR PPS) (no increase).

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16) Information and questions regarding these Adopted Amendments shall be directed to:

Name: Joanne Jones
Bureau of Rules and Regulations

Address: Illinois Department of Public Aid
Jesse B. Harris Building II
100 South Grand Avenue East, 3rd Floor
Springfield, Illinois 62762

Telephone: (217) 524-3215

The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 148
HOSPITAL SERVICES

Section
148.10 Hospital Services
148.20 Participation
148.30 General Requirements
148.40 Special Requirements
148.50 Covered Hospital Services
148.60 Hospital Services Not Covered
148.70 Limitation On Hospital Services
148.80 Organ Transplants Services Covered Under Medicaid
148.90 Heart Transplants (Repealed)
148.100 Liver Transplants (Repealed)
148.110 Bone Marrow Transplants (Repealed)
148.120 Disproportionate Share Hospital Adjustments
148.130 ~~Payment for Inpatient Services for GA~~ Outlier Adjustments for Exceptionally Costly Stays
148.140 Hospital Outpatient and Clinic Services
148.150 ~~Payment for Hospital Services During Fiscal Year 1982~~ Uncompensated Care Payment Adjustment for Nondisproportionate Share Hospitals
148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million
148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million
148.180 Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting
148.190 Copayments
148.200 ~~Payment Methodology~~ Alternate Reimbursement Systems
148.210 ~~Non-Participating Hospitals~~ Filing Cost Reports
148.220 Pre ~~July 1, 1989 Services~~ September 1, 1991 Admissions
148.230 ~~Post June 30, 1989 Services~~ Admissions Occurring on or after September 1, 1991
148.240 Prepayment and Utilization Review
148.250 ~~Base Year Costs~~ Determination of Alternate Payment Rates to Certain Exempt Hospitals
148.260 ~~Restructuring Adjustment~~ Calculation and Definitions of Inpatient Per Diem Rates

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AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1989, ch. 111 1/2, par. 6503-1 et seq.) and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13)

SOURCE: Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991,

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for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE.

Section 148.20 Participation

Payment for inpatient and outpatient hospital services shall be made only to a hospital and for the following types of care:

a) General/Specialty,

b) Psychiatric,

c) Rehabilitation, and

d) End-Stage Renal Disease Treatment

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.40 Special Requirements

a) Approval by Appropriate State Agency to Provide Certain Services

To provide services, other than general in-patient and out-patient services, a hospital must be approved by the appropriate State agency to furnish the following services:

~~a)~~ 1) Psychiatric Services

Payment for hospital psychiatric services shall be made only to a hospital that is a general hospital with a functional unit which specializes in, and is enrolled with the Department to provide, psychiatric services or, a hospital which holds a valid license as, and is enrolled with the Department as, a psychiatric hospital. Federal Medicaid regulations preclude payment for patients over the age of 20 or under the age of 65 in any Institution for Mental Diseases (IMD). Therefore, psychiatric hospitals may not receive reimbursement for services provided to patients over the age of 20 or under the age of 65. A

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Section 148.40 Special Requirements (Cont'd)

psychiatric hospital must be accredited by the Joint Commission on the Accreditation of Health Care Organizations to provide services to program participants under age 21 or be Medicare certified to provide services to program participants age 65 and older. Either the specialized psychiatric unit or the psychiatric hospital must execute an interagency agreement with a DMHDD-operated mental health center for coordination of services, including but not limited to crisis screening and discharge planning to ensure linkage to aftercare services with private practitioners or community mental health services. A participating hospital not enrolled for in-patient psychiatric services may provide psychiatric care as a general in-patient service only on an emergency basis for a maximum period of 72 hours or in cases in which the psychiatric hours or in cases in which the psychiatric services are secondary to the services for which the period of hospitalization is approved.

~~b)~~ 2) Rehabilitation Services

~~1)~~ A) Payment for rehabilitation services shall be made only to a general hospital with a functional unit of the hospital which specializes in, and is enrolled with the Department to provide, physical rehabilitation services or a hospital which holds a valid license as, and is enrolled with the Department as, a physical rehabilitation hospital.

~~2)~~ B) For payment to be made, a rehabilitation facility must be certified by the Health Care Financing Administration for participation under Medicare Program (Title XIII) and must be licensed and/or certified by the Illinois Department of Public Health to provide comprehensive physical rehabilitation services. Out-of-state hospitals which specialize in physical rehabilitation services must be licensed and/or certified to provide comprehensive physical rehabilitation services by the

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Section 148.40 Special Requirements (Cont'd)

authorized licensing agency in the state in which the hospital is located. A rehabilitation facility must provide comprehensive coordinated services of specialists in fields of medicine, nursing, physical therapy, occupational therapy, speech therapy, social work, vocational rehabilitation, clinical psychology, orthotics and prosthetics; and have adequate space and equipment to provide comprehensive diagnostic and treatment services; and maintain records of diagnosis, treatment progress at regular intervals, and functional results. The hospital shall provide ~~periodic~~ written reports as required by ~~to the recipient's referring physician with a copy to the~~ Department of Public Aid. ~~as follows:~~

~~A) after the initial evaluation of the recipient,~~

~~B) monthly progress reports, and~~

~~C) a discharge summary.~~

~~3) A decision to deny or approve a request for prior approval will be made within 30 days of the date of the request and needed information is received by the Department. Prior approval is not required for the first 30 days of service.~~

~~c)~~ 3) The Department provides payment to hospitals for End-Stage Renal Disease Treatment (ESRDT) services only when the services are provided as follows:

~~1)~~ A) Inpatient hospital care is provided for the evaluation and treatment of acute renal disease;

~~2)~~ B) Outpatient chronic renal dialysis treatments are provided in the outpatient renal dialysis department of the hospital and/or in a satellite unit of the hospital, or in a free-standing chronic dialysis center certified by Medicare pursuant to 42 CFR

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Section 148.40 Special Requirements (Cont'd)

405, Subparts S and U (1984), and the recipient is approved by the Illinois Department of Public Health (IDPH) as eligible for ESRDT services; or

~~3)~~ C) Home dialysis treatments are provided through the outpatient renal dialysis department of the hospital and/or in a satellite unit of the hospital, or through a free-standing chronic dialysis center certified by Medicare pursuant to 42 CFR 405, Subparts S and U (1984), and the recipient is approved by IDPH as eligible for ESRDT services.

b) Transition to the Diagnosis Related Grouping Prospective Payment System (DRG PPS)

1) Effective with admissions occurring on or after September 1, 1991, hospitals shall be reimbursed in accordance with 89 Ill. Adm. Code 148.160, 148.170, 148.240 through 148.300, or Part 149, as applicable.

2) Hospitals that, on August 31, 1991, had a contract in effect with the Department under the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1991, ch. 23, par. 6501-1 et seq.) may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care.

3) Effective September 1, 1991, for hospitals located in rural areas, those hospitals that shall be treated as sole community hospitals, as described in 89 Ill. Adm. Code 149.125(b) shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient services:

A) the DRG PPS, as described in 89 Ill. Adm. Code 149, or

B) the rate calculated under 89 Ill. Adm. Code 148.240 through 148.300.

c) Annual Irrevocable Election

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Section 148.40 Special Requirements (Cont'd)

1) Hospitals described in subsections (b)(2) and (b)(3) above may elect to be reimbursed under the special arrangements described in subsections (b)(2) and (b)(3) above on an annual basis.

2) Once a sole community hospital elects to be reimbursed under the DRG PPS, it may not later in that year elect to be classified as exempt. Once a sole community hospital elects to be reimbursed as exempt, it may not later in that year elect to be reimbursed under the DRG PPS. The sole community hospital shall be locked into the reimbursement choice from September 1 through August 30 of the year for which the election was made.

3) Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care. Once such election has been made, the hospital may not later in that year elect to be reimbursed under any other methodology. The hospital shall be locked into the reimbursement choice from September 1 through August 31 of the year for which the election was made.

4) Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act and have elected to be reimbursed under the DRG PPS may not later elect to be reimbursed at rates stated in such contracts.

d) Notification of Reimbursement Methodology for Admissions Occurring on or After September 1, 1991

1) Hospitals shall receive notification from the Department with respect to the reimbursement methodologies that shall be in effect for admissions occurring on or after September 1, 1991.

2) Hospitals described in subsection (b)(2) and (b)(3) above shall receive notification of their

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Section 148.40 Special Requirements (Cont'd)

reimbursement options accompanied by a Choice of Reimbursement form. Each hospital described in subsections (b)(2) and (b)(3) above shall have thirty (30) days from the date of such notification to file, with the Department, the reimbursement method of choice. In the event the Department has not received the hospital's Choice of Reimbursement form within thirty (30) days from the date of notification, as described above, the hospital will automatically be reimbursed under the reimbursement methodology that would have been in effect without benefit of the election described in subsection (c) above.

3) Hospitals meeting specific enrollment criteria as described in subsections (a)(1) and (a)(2) above may enroll to provide such services within thirty days of the notification described in subsection (d)(1) above. Hospitals that request enrollment for Inpatient Psychiatric Services (category of service 21) or Inpatient Physical Rehabilitation Services (category of service 22) within thirty days of the notification described in subsection (d)(1) above shall be enrolled for such service(s) with an effective date of September 1, 1991. Hospitals that do not request enrollment for such service(s) within the time period described above shall not be eligible for retroactive enrollment.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.60 Hospital Services Not Covered

Payment for the following services shall not be made to a hospital, even though provided in a hospital.

a) Private Duty Nursing Services

1) Hospitals shall provide all required nursing services. Only in extraordinary instances in which a recipient's condition or the type of care needed requires many more hours of professional nursing service than the hospital can be expected

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NOTICE OF ADOPTED AMENDMENTS

Section 148.60 Hospital Services Not Covered (Cont'd)

to provide will approval of a private duty nurse, either a registered nurse or a licensed practical nurse, be considered by the Department.

2) Payment for private duty nursing services shall be made only to the nurse and only when prior approval has been given. A decision to approve or deny a request for private duty nursing service shall be made within one day of the date of the request. Written notice of the determination shall be provided within ten days.

b) Sitter Services

1) Sitter services shall be provided only in those rare instances in which the condition of a hospitalized recipient necessitates a sitter to watch at the bedside; and consideration will be given to approval by the Department only in those unusual cases in which hospital staff, volunteers, relatives or friends of the recipient are unable to provide the services.

2) Payment for sitter services shall be made only to the person providing the service and only when prior approval has been given.

c) Nurse Anesthetist Services

Payment for general anesthesia services not reimbursed under 89 Ill. Adm. Code 140.400 shall be made only to hospitals that qualify for these payments under the Medicare Program (Title XIII) and shall be made to such hospitals when provided by a hospital employed nonphysician anesthetist (Certified Registered Nurse Anesthetist or "CRNA") ~~by a nurse anesthetist shall be made only to a certified nurse anesthetist who is not on the staff of the hospital~~.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.70 Limitation On Hospital Services

a) Payment for inpatient hospital care in general and special hospitals shall be made only when it is

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Section 148.70 Limitation On Hospital Services (Cont'd)

recommended by a qualified physician, and the care is essential as determined by the appropriate utilization review authority. For hospitals and/or distinct part units reimbursed on a per diem basis under 89 Ill. Adm. Code 148.160 through 148.170 and 148.240 through 148.300, Payment-payment shall not exceed the number of days approved for the recipient's care by the appropriate utilization review authority. If Medicare benefits are not paid because of non-approval by the utilization review authority, payment shall not be made on behalf of the Department.

b) ~~Hospitals shall notify the Department of each recipient admission within two (2) calendar days of the admission.~~--For hospitals and/or distinct part units reimbursed on a per case basis, payment for inpatient hospital services shall be made in accordance with 89 Ill. Adm. Code Part 149.

c) For hospitals and/or distinct part units reimbursed on a per diem basis, under 89 Ill. Adm. Code 148.160 through 148.170 and 148.240 through 148.300, Payment-payment for in-patient hospital services shall be made based on calendar days. The day of admission shall be counted. The day of discharge shall not be counted. An admission with discharge on the same day shall be counted as one day. If a recipient is admitted, discharged and re-admitted on the same day, only one day shall be counted.

d) In obstetrical cases, payment for services to both the mother and the newborn child shall be made at one per diem rate, or one per case rate, whichever is applicable. Only in instances in which the medical condition of the newborn, as certified by the utilization review authority, necessitates care in other than the newborn nursery, shall payment be made in the child's name.

e) Payment for all in-patient psychiatric services is subject to a prepayment review. All prepayment review shall be conducted by the Department's designated peer review agent. Prepayment review shall be used to determine the appropriateness and necessity of the inpatient psychiatric care. Only inpatient psychiatric care medically necessary as determined by

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 148.70 Limitation On Hospital Services (Cont'd)

a physician licensed to practice medicine in all its branches, will be reimbursed by the Department. The following criteria exemplify the factors which shall be used to determine the medical necessity of inpatient psychiatric care:

1) The patient's condition indicates that he or she suffers from an acute psychological or physiological disorder requiring inpatient hospital intervention (including but not limited to: acute disabling symptoms as a response to bio-psycho-social stress; acute danger to self or others; the medical necessity for interventions possible only in an inpatient hospital setting); and

2) A comprehensive treatment plan has been developed and progress documented for the patient (including, but not limited to: physician's progress notes; participation in medical psychotherapy; assessment of available rehabilitative resources; creation of treatment goals).

f) ~~Payment for physical rehabilitation services shall be made only when prior approval of the Department has been given.--If additional time is required for care beyond the period initially approved, it must be authorized in advance by the Department.~~--Payment for transplant costs (with the exception of kidney and cornea transplants), including acquisition costs, shall be made only when provided by an approved transplantation center as described in 89 Ill. Adm. Code 148.80(c) through (h). Payment for kidney and cornea transplant costs does not require enrollment as an approved transplantation center. Payment for kidney acquisition costs does not require enrollment as an approved transplantation center.

g) Payment for end-stage renal disease treatment shall be made only when provided to recipients who have been screened by and meet medical criteria established by the Department of Public Health.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

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Section 148.80 Organ Transplants Services Covered Under Medicaid

~~a) Hospital services rendered for transplant procedures under Section 148.80(b) are exempt from the provisions of Section 148.200 through 148.330 of the Department's rules governing hospital reimbursement. --Hospital reimbursement for transplants approved pursuant to Section 148.80(b) or Sections 148.90 thru 148.110 will be negotiated between the Department and the hospital with the maximum payment limited to 60% of the hospital's usual and customary charges to the general public for the same procedure. --All negotiated rates must be finalized prior to the occurrence of the transplant procedure. --The negotiated rate will include all work up, hospitalization costs, and thirty days of follow up care. --The negotiated rate will not include transportation and physician fees when reimbursed pursuant to 89 Ill. Adm. Code 140.410 through 140.414 and 89 Ill. Adm. Code 140.490 through 140.492 respectively.~~

~~b) Department approval of the medical necessity and appropriateness of transplant procedures is granted on a case by case prior approval basis by the Department's physician consultants in conjunction with the State Medical Advisory Committee (see Ill. Rev. Stat. 1987, ch. 23, par. 12-4.20) within thirty days of the request for prior approval. --(See 89 Ill. Adm. Code 140 Table E). --Transplant procedures will not be approved if:~~

~~1) the procedure is classified as experimental at this time by the State Medical Advisory Committee based upon current reports from the National Institute of Health, the Illinois Department of Public Health's Experimental Organ Transplantation Procedures Board, the American Medical Association's Council on Scientific Affairs, as well as current scientific literature;~~

~~2) another procedure costing less or of less risk will achieve the same result;~~

~~3) the transplant does not make a difference in the patient's health and performing the transplant will merely serve an academic purpose; or~~

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Section 148.80 Organ Transplants Services Covered Under Medicaid (Cont'd)

~~4) the transplant is relatively unsafe given the age and prognosis of the individual.~~

a) Introduction

The Department of Public Aid will cover organ transplants as identified under subsection (b) which are provided by certified organ transplant centers which meet the requirements specified in subsections (c) through (h).

b) Covered Services

1) Bone Marrow, heart, or liver transplantation excluding bone marrow searches.

2) Other types of transplant procedures may be covered when a hospital has been certified by the Department as a transplant center eligible to perform such transplants. Centers must complete the certification process established in Section 148.80(c) and provide the necessary documentation of the number of transplant procedures performed and the survival rates.

3) Medically necessary work-up and evaluation up to three (3) days prior to transplantation.

c) Certification Process

1) In order to be certified to receive reimbursement for transplants performed on Medicaid patients, the hospital must:

A) Request an application from the Bureau of Hospital Services;

B) Submit a completed application to the Department for the type of transplant for which the center is seeking certification;

C) Meet certification criteria established in subsection (d), based upon review and recommendation of each application by the State Medical Advisory Committee (SMAC); and

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Section 148.80 Organ Transplants Services Covered Under Medicaid (Cont'd)

D) Submit a detailed status report on each patient for the type of transplant for which the hospital is seeking certification. Such reports must include the date of transplant, the length of hospitalization, charges, survival rates, patient-specific transplant outcome, and complications (including cause of death, if applicable) for all transplants performed for the two years preceding the date of the application. To protect the privacy of patients included in this report, names of Medicaid and non-Medicaid patients are not required.

2) The Department shall notify the hospital of approval or denial of the hospital as a transplant center for Medicaid eligible patients.

d) Certification Criteria

1) Hospitals seeking certification as a transplant center shall submit documentation to verify that:

A) The hospital is located in the State of Illinois or the city of St. Louis, Missouri;

B) The hospital is a tertiary care hospital capable of providing all necessary medical care required by the transplant patient;

C) The hospital is affiliated with an academic health center;

D) The hospital has had the transplant program in operation for at least three years with twelve transplant procedures per year for the past two years and twelve cases before that for adult heart and liver transplants and for adult and pediatric bone marrow transplants;

E) A hospital specializing in pediatric heart and/or liver transplants must have a program in operation for at least three years and must have performed a minimum of six

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Section 148.80 Organ Transplants Services Covered Under Medicaid (Cont'd)

transplant procedures per year for the past two years, and six before that;

F) The hospital has experts, on staff, in the fields of cardiology, anesthesiology, immunology, infectious disease, nursing, social services, organ procurement, associated surgery and internal medicine to complement the transplant team. In addition, in order to qualify as a transplant center for pediatric patients, the hospital must also have experts in the field of pediatrics;

G) The hospital has an active cardiovascular medical and surgical program as evidenced by the number of cardiac catheterizations, coronary arteriograms and open heart procedures per year for heart transplant candidates;

H) The hospital has pathology resources that are available for studying and reporting the pathological responses for transplantation;

I) The hospital complies with applicable State and Federal laws and regulations;

J) The hospital participates in a recognized national donor procurement program, abides by its rules, and provides the Department with the name of the national organization of which it is a member;

K) The hospital has an interdisciplinary body to determine the suitability of candidates for transplantation;

L) The hospital has blood bank support necessary to meet the demands of a certified transplant center; and

M) The hospital meets the applicable transplant survival rates as supported by the Kaplan-Meier method or other method accepted by the Department;

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Section 148.80 Organ Transplants Services Covered Under Medicaid (Cont'd)

i) A one-year survival rate of 50 percent for bone marrow transplant patients;

ii) A one-year survival rate of 75 percent and a two-year survival rate of 60 percent for heart transplant patients;

iii) A one-year survival rate of 75 percent and a two-year survival rate of 60 percent for liver transplant patients.

2) The commitment of the hospital to support the transplant center must be at all levels as evidenced by such factors as financial resources, allocation of space and the support of the professional staff for the transplant program and its patients. The hospital must demonstrate that:

A) Component teams are integrated into a comprehensive transplant team with clearly defined leadership and responsibility;

B) The hospital safeguards the rights and privacy of patients;

C) The hospital has adequate patient management plans and protocols to meet the patient and hospital's needs.

3) The hospital must identify, in writing, the director of the transplant program and the members of the team as well as their qualifications. Physician team members must be identified as board certified, in preparation for board certification, or pending board certification, and the transplant coordinator's name must be submitted.

4) The hospital must provide patient selection criteria including indications and contraindications for the type of transplant procedure for which the facility is seeking certification.

e) Recertification Process/Criteria

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Section 148.80 Organ Transplants Services Covered Under Medicaid (Cont'd)

1) The Department will conduct an annual review for certification of transplant centers. A certified center must submit documentation established under subsections (c), (d), (f) and (h) for review by the Department's State Medical Advisory Committee for recertification as a transplant center.

2) Survival rates of previous transplant patients must be documented prior to certification. The center must maintain patient volume in the year of certification based on previous transplant statistics.

3) The Department shall notify the hospital of approval or denial of the recertification of the hospital as a transplant center.

f) Notification of Transplant

1) The hospital must notify the Department prior to performance of the transplant procedure.

2) The notification must include the admission diagnosis, pre-transplant diagnosis and the initial work-up summary of medical findings.

3) The Department shall notify the hospital regarding receipt of the notification and provide the appropriate "patient tracking" forms to the hospital.

g) Reimbursement

1) Hospital services rendered for transplant procedures under this Section are exempt from the provisions of Sections 148.240 through 148.330 and Part 149 of the Department's administrative rules governing hospital reimbursement. Hospital reimbursement for transplants covered within Section 148.80 is an all-inclusive rate for the admission, regardless of the number of days of care associated with that admission, which is limited to a maximum of 60 percent of the hospital's usual and customary charges to the

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Section 148.80 Organ Transplants Services Covered Under Medicaid (Cont'd)

general public for the same procedure for the number of days listed below for specific types of transplants:

A) Three days of pre-operative inpatient work-up; and

B) A maximum 30 consecutive days of post-operative inpatient care for heart transplant; or

C) 40 consecutive days of inpatient care for liver transplant; or

D) 50 consecutive days of inpatient care for bone marrow transplant; or

E) For those transplants covered under subsection (b)(2), the number of consecutive days of inpatient care specified within the transplant certification process.

2) Reimbursement will be approved only when the Department's letter acknowledging the notification of the transplant procedure is attached to the hospital's claim.

3) Applicable disproportionate share payment adjustments shall be made in accordance with 89 Ill. Adm. Code 148.120(g). Applicable outlier adjustments shall be made in accordance with 89 Ill. Adm. Code 148.130(d).

4) The rate will not include transportation and physician fees when reimbursed pursuant to 89 Ill. Adm. Code 140.410 through 140.414 and 89 Ill. Adm. Code 140.490 through 140.492, respectively.

h) Reporting Requirements of Certified Transplant Center

The following documentation must be submitted within the time limits set forth in this subsection.

1) Patient Tracking

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Section 148.80 Organ Transplants Services Covered Under Medicaid (Cont'd)

A) The center must submit annually a statistical summary including information for all patients having received transplants at the transplant center. Patients not covered by Medicaid may be identified numerically or by other means identified by the hospital, to protect patient confidentiality. The summary must include, but is not limited to, short and long term outcome on all patients.

B) The discharge summary for each Medicaid patient must be received by the Department within thirty days of the patient's discharge.

C) The annual outcome summaries for each Medicaid patient must be received by the Department within thirty days of the annual patient post-transplant evaluation.

D) For those Medicaid patients who expire, a summary must be received by the Department within thirty days of the patient's death.

2) Notification of Changes

The center must notify the Department within thirty days of any changes in its program including, but not limited to, certification criteria, patient selection criteria, members of the transplant team and the coordinator.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.90 Heart Transplants (Repealed)

~~Application for prior approval of a heart transplant should originate from a transplantation center recognized by the Department as a "participating" center; should be submitted only after patient evaluation and a decision by the transplant "team" that patient is a "good" candidate for transplantation.~~

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Section 148.90 Heart Transplants (Repealed) (Cont'd)

a) Criteria for coverage. Services and supplies related to cardiac transplantation will be covered for a beneficiary:

1) who has an end-stage cardiac disease in irreversible heart failure;

2) who has not responded to or no longer responds to other appropriate medical and surgical therapies which might be expected to yield both short and long term survival (e.g., 3-5 years) comparable to that of heart transplantation;

3) who has a very poor prognosis as a result of poor cardiac functional status (e.g., less than a 25 percent likelihood of survival for six months);

4) for whom plans for long term adherence to a disciplined medical regimen are feasible and realistic;

5) who has rehabilitation potential with the probability of becoming an active member of society (e.g., is able to participate in activities of daily living); and

6) who has immediate family members or close friends available to provide support and care during the post transplantation period.

b) Strongly adverse factors include the following conditions:

1) Advancing age (because of diminished capacity to withstand postoperative complications). The selection of any patients for transplantation must be done with particular care to ensure a physiologic age capable of withstanding postoperative complications and the absence or insignificance of any coexisting disease as certified by the center.

2) History of a behavior pattern such as chemical dependency, alcoholism, drug dependency, or psychiatric illness considered likely to interfere with compliance with a disciplined

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Section 148.90 Heart Transplants (Repealed) (Cont'd)

medical regimen (because a lifelong medical regimen is necessary, requiring multiple drugs several times a day, with serious consequences in the event of their interruption or excessive consumption);

3) Severe pulmonary hypertension (because of the limited work capacity of the typical donor right ventricle). A pulmonary vascular resistance above 5 Wood units or pulmonary artery systolic pressure over 65 mm Hg is considered to be severe pulmonary hypertension;

4) Renal or hepatic dysfunction not explained by the underlying heart failure and not deemed reversible (because of the nephrotoxicity and hepatotoxicity of cyclosporin);

5) Acute severe hemodynamic compromise prior to transplantation if accompanied by compromise or failure of a vital end organ (because of a substantially less favorable prognosis for survival than for the average transplant recipient);

6) Symptomatic peripheral or cerebrovascular disease (because of accelerated progression in some patients after cardiac transplantation and chronic corticosteroid treatment);

7) Chronic obstructive pulmonary disease or chronic bronchitis (because of poor postoperative course and likelihood of exacerbation of infection with immunosuppression);

8) Active systemic infection (because of the likelihood of exacerbation with initiation of immunosuppression) including Human Immunodeficiency Virus (HIV) positive individuals;

9) Recent and unresolved pulmonary infarction or pulmonary roentgenographic evidence of infection or of abnormalities of unclear etiology (because of the likelihood that this represents pulmonary infection);

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Section 148.90 Heart Transplants (Repealed) (Cont'd)

10) Systemic hypertension, either at transplantation or prior to development of end-stage cardiac disease, that requires multi-drug therapy for even moderate control (multidrugs to bring diastolic pressure below 105 mm Hg);

11) Systemic disease considered likely to limit or preclude survival and rehabilitation after transplantation;

12) Cachexia, even in the absence of major end organ failure (because of the significantly less favorable survival of such patients); and

e) Other factors given less adverse weight but still considered as importantly adverse include:

1) Insulin requiring diabetes mellitus (because the diabetes is often accompanied by occult vascular disease and because the diabetes and its complications are exacerbated by chronic corticosteroid therapy);

2) Asymptomatic severe peripheral or cerebrovascular disease (because of accelerated progression in some patients after cardiac transplantation and chronic corticosteroid treatment);

3) Peptic ulcer disease (because of the likelihood of early postoperative exacerbation);

4) Current or recent history of diverticulitis (considered as a source of active infection which may be exacerbated with the initiation of immunosuppressant therapy); and

5) Previous life threatening malignancy unless no clinical evidence of disease for five years.

d) Even though the beneficiary may meet the general criteria for a heart transplant as listed in subsection (a), such a transplant is contraindicated when any of the adverse factors listed in subsections (b) or (c) above are present. Although cases in these groups will not be categorically denied, a second medical opinion by a cardiologist or cardiothoracic surgeon must be conducted to ascertain that the transplant is medically appropriate in view of the circumstances.

e) The donor heart should be appropriate for that particular recipient. The use of a donor heart, the long term effectiveness of which might be compromised by such actions as the use of substantial vasopressors prior to its removal from the donor, its prolonged or compromised maintenance between the time of its removal from the donor and its implantation into the patient, or pre existing disease.

f) Covered Services for Medicaid Recipients

1) Medically necessary services, including inpatient admission, required to assess a patient's suitability for heart transplantation;

2) Medically necessary services required, including management of complications, of the heart transplantation. Failure of the transplant is considered a complication and retransplantation is covered; and

3) Immunosuppressive therapy.

g) Requirements for Provider Participation

1) Approval by the Illinois Department of Public Health (IDPH) as a heart transplant center (see Sections 1 thru 5 of the Experimental Organ Transplantation Procedures Act, Ill. Rev. Stat. 1987, ch. 111 1/2, pars. 6601 thru 6605 and 77 Ill. Adm. Code 2800.101 thru 2800.501).

2) Approval of heart transplant centers may also be granted based upon Medicare certification as an authorized heart transplant center.

3) Transplant centers not approved by IDPH or Medicare may apply for approval for transplant procedures to the Department if they meet the following specific criteria:

A) The center has experts in the fields of cardiology, cardiovascular surgery, anesthesiology, immunology, infectious

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disease, nursing, social services, and organ procurement to complement the transplant team;

B) The center has an active cardiovascular medical and surgical program as evidenced by the number of cardiac catheterizations, coronary arteriograms and open heart procedures per year;

C) The center has an anesthesia team that is available at all times;

D) The center has infectious disease services with both the professional skills and the laboratory resources that are needed to discover, identify and manage a whole range of organisms;

E) The center has a nursing service team trained in the hemodynamic support of the patient and also in the special problems of managing immunosuppressed patients;

F) The center has pathology resources that are available for studying and reporting the pathological responses to transplantation;

G) The center has legal counsel familiar with transplantation and regulations;

H) The commitment of the transplant center must be at all levels as evidenced by such factors as financial resources, allocation of space and the support of the professional staff;

I) Physician team members must be on track (i.e., pending or in preparation for board certification) or board certified;

J) Component teams must be integrated into a comprehensive transplant team with clearly defined leadership and responsibility;

K) The center has the necessary social service

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Section 148.90 Heart Transplants (Repealed) (Cont'd)

resources to allow for assignment to the organ transplant program;

L) The transplant center must comply with applicable State laws and regulations;

M) The transplant center must safeguard the rights and privacy of patients;

N) The transplant center must have adequate patient management plans and protocols to meet the patient and hospital's needs;

O) The center participates in a donor procurement program and is a member of the Organ Procurement Transplantation Network and abides by its rules;

P) The center systematically collects and shares data on its transplant program;

Q) The center has an interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis;

R) The center must have blood bank support to meet the demands of the transplant center;

S) Experience. The center has performed six or more cardiac transplants in each of the two consecutive preceding 12 month periods prior to application and 12 prior to that; and

T) Survival Rates. The center demonstrates actuarial survival rates of 50 percent for two years for patients and rehabilitation to level of participation in former work and activities in more than 30% who have had heart transplants since January 1, 1982, at that facility.

4) Negative decisions on applications may be appealed to the Chief, Bureau of Hospital Services.

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Section 148.90 Heart Transplants (Repealed) (Cont'd)

h) Participation approval will lapse if either the number of heart transplants falls below six in 12 months or if the one-year survival rate falls below 60 percent based on a consecutive 24-month period.

i) Provider Participation Procedures. A heart transplant center wishing to be granted approval as a Medicaid approved heart transplantation center must submit evidence that its heart transplantation program meets the criteria in subsection (f). Requirements for Provider Participation. The request must be submitted to the Bureau of Hospital Services.

j) Administrative Provider Requirements. The transplant program must provide a written statement agreeing to the following:

The heart transplant center shall notify the Department of any decrease in the experience level or survival rates and loss of any key members of the transplant team.

k) Reimbursement. Will be as stated in the facility's Illinois Competitive Access and Reimbursement Equity (ICARE) contract or if an approved facility does not have an ICARE contract, reimbursement will be limited to 60% of the usual and customary charges to the general public for the same procedure. All negotiated rates must be finalized prior to the occurrence of the transplant procedure.

(Source: Repealed at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.100 Liver Transplants (Repealed)

Application for prior approval of a liver transplant should originate from a transplantation center recognized by the Department as a "participating" center; should be submitted only after patient evaluation and a decision by the transplant "team" that patient is a "good" candidate for transplantation.

a) Criteria for Coverage. Services and supplies related to liver transplantation will be covered for recipients who:

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Section 148.100 Liver Transplants (Repealed) (Cont'd)

1) are suffering irreversible end stage liver failure that cannot be managed by conservative measures;

2) have exhausted alternative medical and surgical treatments; and

3) are approaching the terminal phase of their illness (e.g., death is imminent or irreversible damage to the central nervous system is inevitable).

b) Medical indications for liver transplantation:

1) Biliary atresia;

2) Chronic active hepatitis in patients who have almost no chance of survival beyond six months. Indications of progression to a terminal phase include rapidly deepening jaundice, diuretic resistant ascites, spontaneous hepatic encephalopathy, recurrent septicemia and repeated bleeding esophageal varices;

3) Primary biliary cirrhosis in the final stages of liver failure;

4) Certain inborn errors of metabolism which have caused end stage liver damage or irreversible extrahepatic complications, including alpha-1 antitrypsin deficiency in children with Pi-ZZ phenotype and adults with phenotype Pi-ZZ, -MZ, or -SZ where evidence of hepatic failure is present; Wilson's disease unresponsive to chelation therapy with penicillamine; Crigler-Najjar syndrome, Type I; tyrosinemia; Byler's disease; Wolman's disease; glycogen storage disease, types O and IV; and certain genetic diseases associated with severe neurological complications, such as hereditary deficiency of urea cycle enzymes and disorders of lactate/pyruvate or amino acid metabolism;

5) Hepatic vein thrombosis (Budd-Chiari syndrome) in patients with severe hepatic decompensation, who have not responded to anticoagulation or appropriate surgery for portal decompression;

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Section 148.100 Liver Transplants (Repealed) (Cont'd)

6) Primary sclerosing cholangitis when attempts at biliary tract diversion and dilation if appropriate have failed; and

7) Primary hepatic malignancy confined to the liver but not amenable to resection.

e) Contraindications

1) History of a behavior pattern such as chemical dependency, alcoholism or drug dependency or psychiatric illness considered likely to interfere significantly with compliance with a disciplined medical regimen;

2) Malignancies metastasized to or extending beyond the margins of the liver;

3) Viral induced liver disease when viremia is still present;

4) Alcoholic liver disease in patients who develop evidence of progressive liver failure despite appropriate medical treatment and cessation of alcohol abuse; or

5) A previous life threatening malignancy unless no clinical evidence of disease for five years.

6) Active systemic infection (because of the likelihood of exacerbation with initiation of immunosuppression) including HIV positive individuals.

d) Covered Services for Medicaid Recipients. The following services are covered when provided in relation to liver transplantation:

1) Medically necessary services, including inpatient admission, required to assess a patient's suitability for liver transplantation;

2) All medically necessary services required including management of complications of the liver transplantation, including late infection and rejection episodes. Failure of the transplant is considered a complication and retransplantation is covered; and

3) Immunosuppressive therapy.

e) Requirements for Provider Participation. The transplant center must meet the following requirements:

1) Approval by IDPH as a liver transplant center.

2) Transplant centers not approved by IDPH may apply for approval for transplant procedures to the Department if they meet the following specific criteria:

A) The center is a tertiary care facility affiliated with an academic health center. (A tertiary care facility is a hospital which can provide all medical care required by a patient.) The center has accredited programs in graduate medical education related to the function of liver transplantation such as internal medicine, pediatrics, surgery, and anesthesiology;

B) The center has at least a 50 percent one year survival rate for ten cases. At the time participation is requested, the transplant center must have performed at least ten liver transplants and at least 50 percent of the transplanted patients have survived one year following surgery. The 50 percent one year survival rate for all subsequent liver transplantations performed is to be maintained for continued participation;

C) The center has an active liver transplantation program;

D) The center has allocated operating room, recovery room, laboratory, and blood bank support and a number of intensive care and general surgical beds and specialized staff for these areas to care for the projected size of the transplantation program;

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Section 148.100 Liver Transplants (Repealed) (Cont'd)

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Section 148.100 Liver Transplants (Repealed) (Cont'd)

E) The center participates in a donor procurement program and is a member of the Organ Procurement Transplantation Network and abides by its rules;

F) The center systematically collects and shares data on its transplant program;

G) The center has an interdisciplinary body to determine the suitability of candidates for transplantation on an equitable basis;

H) The transplantation surgeon is specifically trained for liver grafting and must assemble and train a team to function whenever a donor liver is available;

I) The transplantation center has on staff on track or board certified physicians and other experts in the fields of hepatology, pediatrics, infectious disease, nephrology with dialysis capability, pulmonary medicine with respiratory therapy support, pathology, immunology, and anesthesiology to complement a qualified transplant team;

J) The transplantation center has the assistance of appropriate microbiology, clinical chemistry, and radiology support;

K) The transplantation center has blood bank support to accommodate normal demands and the transplant procedure;

L) The transplantation center includes the availability of psychiatric and social services support for patients and family; and

M) The transplantation center otherwise meets the requirements for participation by the Department.

3) Negative decisions on applications may be appealed to the Chief, Bureau of Hospital Services.

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Section 148.100 Liver Transplants (Repealed) (Cont'd)

f) Provider certification procedures.--A center wishing to be granted approval as a Department participating liver transplantation center must submit evidence that its liver transplantation program meets the criteria in subsection (e) above.--The request must be submitted to the Bureau of Hospital Services.

g) Reimbursement.--Will be as stated in the facility's ICARE contract or if an approved facility does not have an ICARE contract, reimbursement will be limited to 60% of the usual and customary charges to the general public for the same procedure.--All negotiated rates must be finalized prior to the occurrence of the transplant procedure.

(Source: Repealed at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.110 Bone Marrow Transplants (Repealed)

Application for prior approval of a bone marrow transplant should originate from a transplantation center recognized by the Department as a "participating" center; should be submitted only after patient evaluation and a decision by the transplant "team" that patient is a "good" candidate for transplantation.

a) Criteria for Participation
Bone marrow transplantation centers wishing to participate will submit to the Department an application signed by the Chief Medical Officer and the head of the transplant team certifying that the following criteria are met:

1) Careful and appropriate patient selection---- Facility must have written criteria for candidate selection and an implementation plan for their application.

2) Patient management----Facility must have the expertise and commitment for full active participation in the medical, immunological, infectious and pulmonary disease, surgical and anesthesia aspects of the program.

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Section 148.110 Bone Marrow Transplants (Repealed) (Cont'd)

A) The "transplant team", for patient selection and protocol information for the acute and long-term management of patients, should be selected from the above professional groups and must be formally organized for the above purposes. It is from this team that an application for prior approval should originate to be transmitted to the Illinois Department of Public Aid.

B) The facility must have designated professional staff from radiology, pathology, psychiatry, nursing and social services to meet their responsibilities under the Transplant Program. Members of this group also may serve on the transplant team.

C) The commitment of the facility to the Transplant Program must be evident at all levels as well as broadly throughout the facility. This includes building space and equipment needed for the program as it develops, pre-transplant care, donor and patient, surgical procedures and immediate as well as long-term post-transplant stages of the program.

D) The facility must demonstrate experience and success with the clinical transplantation. For recognition as a participating center under the Department, there must be documented at least six such transplanta-tions in the preceding 24 months with actual two-year survival rates of 50 percent or more and rehabilitation to level of participation in former work and activities in more than 30 percent.

E) There must be agreement by the facility to maintain and, when requested, periodically submit summary data, in standard format, about patient selection, and short and long-term outcome on all patients, not only those for whom the Department is paying.

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Section 148.110 Bone Marrow Transplants (Repealed) (Cont'd)

3) Applications will be considered by the Department's physician consultants and the State Medical Advisory Committee.

4) Negative decisions on applications may be appealed to the Chief, Bureau of Hospital Services.

b) Description

Allogenic bone marrow transplantation is the aspiration of marrow from a donor and intravenous infusion of the marrow into a recipient.

c) Policy

Allogenic Histo compatibility antigens (HLA) matching bone marrow transplantation is an authorized therapeutic measure for treatment of the following:

1) Aplastic anemia.

2) Leukemia in remission.

3) Severe combined immunodeficiency, e.g., adenosine deaminase deficiency and idiopathic deficiencies.

4) Wiskott-Aldrich syndrome.

5) Infantile malignant osteopetrosis (Albers-Schonberg syndrome or marble bone disease).

6) Hodgkins and non-Hodgkins Lymphoma.

d) Exceptions

1) Conditions for which allogenic bone marrow transplantation is not yet proven therapeutic and are not covered are:

A) Thalassemia and other genetic disorders.

B) Sickle cell anemia and other abnormal hemoglobin states.

C) Polycythemia vera.

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Section 148.110 Bone Marrow Transplants (Repealed) (Cont'd)

~~D) Neuroblastoma.~~

~~2) Autogenous (autologous) bone marrow transplantations (within the same individual) are considered experimental or investigational and, therefore, excluded from coverage, except in Hodgkins and non-Hodgkins lymphoma.~~

~~e) Contraindications~~

~~1) History of a behavior pattern such as chemical dependency, alcoholism or drug dependency or psychiatric illness considered likely to interfere significantly with compliance with a disciplined medical regimen;~~

~~2) Chronic obstructive pulmonary disease or chronic bronchitis (because of poor postoperative course and likelihood or exacerbation of infection with immunosuppression);~~

~~3) Active systemic infection (because of the likelihood of exacerbation with initiation of immunosuppression) including HIV positive individuals;~~

~~4) Recent and unresolved pulmonary infarction or pulmonary roentgenographic evidence of infection or of abnormalities of unclear etiology (because of the likelihood that this represents pulmonary infection);~~

~~5) Systemic hypertension, either at transplantation or prior to development of end stage cardiac disease, that requires multi drug therapy for even moderate control (multidrugs to bring diastolic pressure below 105 mm Hg);~~

~~6) Diabetes and other systemic disease considered likely to limit or preclude survival and rehabilitation after transplantation; and~~

~~7) Cachexia, even in the absence of major end organ failure (because of the significantly less favorable survival of such patients).~~

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Section 148.110 Bone Marrow Transplants (Repealed) (Cont'd)

~~f) Reimbursement.--Will be as stated in the facility's ICARE contract or if an approved facility does not have an ICARE contract, reimbursement will be limited to 60% of the usual and customary charges to the general public for the same procedure.--All negotiated rates must be finalized prior to the occurrence of the transplant procedure.~~

(Source: Repealed at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.120 Disproportionate Share Hospital Adjustments

a) Qualified Disproportionate Share Hospitals. For inpatient services provided on or after July 1, ~~1989~~ 1991, the Department shall make adjustment payments to hospitals which are deemed as disproportionate share by the Department. A hospital may qualify for a disproportionate share adjustment in one of the following ways:

1) The hospital's Medicaid inpatient utilization rate, in terms of inpatient days of care provided to Title XIX recipients compared to total inpatient days of care provided, is at least one standard deviation above the mean Medicaid utilization rate. Title XIX specifically excludes General Assistance (GA) and Aid to the Medically Indigent (AMI) days but does include Medicare/Medicaid crossover days. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

2) The hospital's low income utilization rate exceeds 25%. For this alternative, payments for all patient services (not just inpatient) for Medicaid, GA, AMI and/or any local or state government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for GA

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Section 148.120 Disproportionate Share Hospital Adjustments (Cont'd)

and AMI inpatient hospital services, and/or any local or state government-funded care) must be added.

3) Illinois hospitals that are located in a federally designated Health Manpower Shortage Area (42 CFR 5, 1989) that have a Medicaid inpatient utilization rate, as defined in subsection (a)(1) above, that is at least the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving medical assistance payments from the Department and which are located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board (77 Ill. Adm. Code 1100).

4) Any children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children that is separately licensed as a hospital by a municipality shall be considered a children's hospital to the degree that the hospital's medical assistance care is provided to children.

5) Critical Care Access Hospitals. Critical Care Access Hospitals are hospitals reimbursed under 89 Ill. Adm. Code 148.240 through 148.300 or Part 149 that meet at least one of the following criteria:

A) The hospital is recognized as a Level I trauma center by the Illinois Department of Public Health or by the licensing agency in the state in which the hospital is located if the hospital is located within 50 miles of an Illinois border.

B) The hospital is recognized as a Level II trauma center by the Illinois Department of Public Health and is located in a rural area.

C) The hospital is recognized as a Level II trauma center by the Illinois Department of

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Section 148.120 Disproportionate Share Hospital Adjustments (Cont'd)

Public Health and is located in an urban area in a county with no Level I trauma center and provides a disproportionate share of trauma services.

i) For hospitals meeting the criteria in subsection (a)(5)(C) above, a disproportionate share of trauma services shall be calculated by dividing each such hospital's medical assistance trauma admissions by the total medical assistance trauma admissions for such hospitals to arrive at the trauma percentage.

ii) For hospitals meeting the criteria in subsection (a)(5)(C) above that are located in a Health Manpower Shortage Area (HMSA), those hospitals with a trauma percentage at or above the mean of the individual facility values determined in subsection (a)(5)(C)(i) above shall be deemed to provide a disproportionate share of trauma services.

iii) For hospitals meeting the criteria in subsection (a)(5)(C) above that are not located in a Health Manpower Shortage Area (HMSA), those hospitals with a trauma percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection (a)(5)(C)(i) above shall be deemed to provide a disproportionate share of trauma services.

D) The hospital is designated as a Level II perinatal center by the Illinois Department of Public Health, is located in a rural area, and provides a disproportionate share of perinatal services.

i) For hospitals meeting the criteria in subsection (a)(5)(D) above, a

disproportionate share of perinatal services shall be calculated by dividing each such hospital's medical assistance perinatal admissions by its total medical assistance admissions to arrive at the perinatal percentage.

ii) For hospitals meeting the criteria in subsection (a)(5)(D) above, those hospitals with a perinatal percentage of 30 percent or above shall be deemed to provide a disproportionate share of perinatal services.

E) The hospital is located in a rural area and provides a disproportionate share of obstetrical services.

i) For hospitals meeting the criteria in subsection (a)(5)(E) above, a disproportionate share of obstetrical services shall be calculated by dividing each such hospital's medical assistance obstetrical admissions by its total medical assistance admissions to arrive at the obstetrical percentage.

ii) For hospitals meeting the criteria in subsection (a)(5)(E) above, those hospitals with an obstetrical percentage of 20 percent or above shall be deemed to provide a disproportionate share of obstetrical services.

b) In addition, to be deemed a disproportionate share hospital, a hospital must provide the Department, in writing, with the names of at least 2 obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to

perform nonemergency obstetric procedures. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer nonemergency obstetric services as of December 21, 1987. Hospitals that do not offer nonemergency obstetrics to the general public must submit a statement to that effect.

c) In making the determination described in subsection (a)(1) above, the Department ~~will use the hospital's cost reports and the Department's paid claims data for the hospital's base fiscal year (i.e., calendar year 1986 for fiscal year 1989 payments, calendar year 1987 for fiscal year 1990, etc.) for information regarding Illinois Medicaid recipient utilization levels. In addition, hospital statements and verification reports from other states will be required to verify out of state Medicaid recipient utilization levels. Also, a hospital that was the recipient of delegated days and did not receive payment directly from the Department (i.e., the delegating hospital received payment from the Department and then reimbursed the recipient hospital) must submit information to the Department identifying the delegating hospital and documenting that the delegated days were provided by the recipient hospital~~ shall utilize:

1) The hospital's final audited cost report for the hospital's base fiscal year (i.e., Calendar Year 1986 for Fiscal Year 1989 payments, Calendar Year 1987 for Fiscal Year 1990, etc.). Medicaid inpatient utilization rates, as defined in subsection (a)(1) above, which have been derived from final audited cost reports, are not subject to the Review Procedure described in 89 Ill. Adm. Code 148.310, with the exception of errors in calculation.

2) In the absence of a final audited cost report for the hospital's base fiscal year (i.e., Calendar Year 1986 for Fiscal Year 1989 payments, Calendar Year 1987 for Fiscal Year 1990, etc.), the Department shall utilize the hospital's unaudited cost report for the hospital's base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a

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Section 148.120 Disproportionate Share Hospital Adjustments (Cont'd)

corrected cost report for the determination described in subsection (a)(1) above. Submittal of a corrected cost report in support of subsection (a)(1) above must be received no later than June 30 of the State's fiscal year immediately preceding the fiscal year for which the hospital is requesting consideration of such corrected cost report for the determination of disproportionate share qualification (i.e., for the FY'92 determination, a corrected cost report must be received no later than June 30, 1991). Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's Medicaid inpatient utilization rate as described in subsection (a)(1) above.

A) Hospitals' Medicaid inpatient utilization rates, as defined in subsection (a)(1) above, which have been derived from unaudited cost reports, are not subject to the Review Procedure described in 89 Ill. Adm. Code 148.310, with the exception of errors in calculation. Pursuant to subsection (c)(2) above, hospitals shall have the opportunity to submit corrected cost report information prior to the Department's final disproportionate share determination.

B) In the event a subsequent final audited cost report reflects a Medicaid inpatient utilization rate, as described in subsection (a)(1) above, which is lower than the Medicaid inpatient utilization rate derived from the unaudited cost report utilized for the disproportionate share determination, the Department shall recalculate the Medicaid inpatient utilization rate based upon the final audited cost report, and recoup any overpayments made.

3) Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid

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crossover claims, out-of-state Title XIX Medicaid utilization levels, and inappropriate level of care days. To obtain Medicaid utilization levels in these instances, the Department shall utilize:

A) Medicare/Medicaid Crossover Claims. The Department will utilize the Department's paid claims data for each hospital's base fiscal year (i.e., Calendar Year 1986 for Fiscal Year 1989 payments, Calendar Year 1987 for Fiscal Year 1990, etc.). Effective with disproportionate share determinations for State Fiscal Year 1992 and after, hospitals may submit additional information to document Medicare/Medicaid crossover days which were not billed to the Department due to a determination that the Department had no liability for deductible and/or coinsurance amounts if the reason for such a determination was made because payments made by Medicare and other third parties exceeded the rate that would have been paid under the Medicaid Program.

B) Out-of-state Title XIX Utilization Levels. Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient utilization levels.

C) Inappropriate Level of Care Days. The Department will utilize the Department's paid claims data for each hospital's base fiscal year (i.e., Calendar Year 1986 for Fiscal Year 1989 payments, Calendar Year 1987 for Fiscal Year 1990, etc.).

d) Hospitals ~~not qualifying as~~ may apply for disproportionate share ~~hospitals by the Department under subsection (a)(1), may be considered~~ status under subsection (a)(2) by submitting a certified financial statement.

e) Payments to Participating Out-of-State Hospitals. For purposes of the determination described in subsection (a)(1) above, out-of-state hospitals will be measured

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in relationship to the mean Medicaid inpatient utilization rate in their state. Out-of-state hospitals which do not qualify by the Medicaid inpatient utilization rate from their state may submit a certified financial statement as described in subsection (d) above. Payments to out-of-state hospitals will be allocated using the same method as described in subsection (g).

f) Time Limitation for Additional Information Requirements. Beginning with State fiscal year 1993 ("FY'93") determinations for disproportionate share, the information required in subsections (a)(2), (b), (c), (d) and (e) and subsection (j)(2)(D) must be received no later than June 30th of the state's fiscal year immediately preceding the fiscal year for which the hospital is requesting consideration of such information for the determination of disproportionate share qualification (i.e., for the FY'93 determination, such information must be received no later than June 30, 1992). Information required in this section which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for disproportionate share.

e)~~f)~~g) Inpatient Payment Adjustments to Disproportionate Share Hospitals. The adjustment payments required by subsection (a) above shall be calculated annually as follows:

1) Hospitals qualifying as disproportionate share hospitals under subsections (a)(1) and (a)(2) will receive an add-on payment to their inpatient rate. The distribution method is based upon a fund of $5M. All hospitals qualifying under subsection (a)(1) and subsection (a)(2) will receive a five dollar ($5) per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data by five dollars ($5). The total dollar amount of this calculation is then subtracted from the $5M fund. The remaining fund balance is then distributed to the hospitals that qualify under

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subsection (a)(1) above in proportion to the percentage by which the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the State's mean Medicaid inpatient utilization rate. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are then multiplied by each hospital's most recent completed fiscal year paid inpatient day values. These weighted values are summed and each hospitals proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the $5M pool of money available after the five dollars ($5) per day base add-on has been subtracted. The total dollar amount calculated for each hospital (plus the initial five dollars ($5) per day add-on amount) is then divided by the inpatient day projections to arrive at per day add-on value. Hospitals qualifying under subsection (a)(2), will receive the minimum adjustment of five dollars ($5) per inpatient day.

2) In addition to the adjustment methodology described in subsection ~~(e)~~(g)(1) above, all disproportionate share hospitals described in subsections (a)(1), (2), (3) and (4) shall receive a payment adjustment which will be calculated annually as follows:

A) The hospital's inpatient payment rate shall be multiplied by .0734, the product which shall then be multiplied by the sum of the following:

i) the hospital's occupancy ratio multiplied by .75;

ii) the hospital's Medicaid inpatient utilization rate; and

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iii) the hospital's Medicare utilization differential.

B) For hospitals paid on a per diem basis and those reimbursed under 89 Ill. Adm. Code 148.80(g), ~~The~~-the amount calculated pursuant to subsection ~~(e)~~(g)(2)(A) above shall be added to 20, and this sum plus any applicable amount calculated under subsections ~~(e)~~(g)(1), (h), (i), (j)(2), (k)(2) and (l)(2) shall be the inpatient payment adjustment in dollars for the applicable fiscal year. The adjustment calculated under this subsection shall be applied to each covered day of care provided.

C) For hospitals paid on a per discharge basis, the amount calculated, pursuant to subsection (g)(2)(A) above, shall be added to 20, the sum of which shall be multiplied by the hospital's average length of stay, and this sum plus any applicable amount calculated under subsections (g)(1), (h), (i), (j)(2), (k)(2) and (l)(2) shall be the inpatient payment adjustment in dollars for the applicable fiscal year.

~~(f)~~(h) Children's Hospital Inpatient Payment Adjustment. For children's hospitals, as defined in subsection (a)(4), the amount calculated pursuant to subsection ~~(e)~~(g)(2)(A) shall be multiplied by 2.0.

i) County Hospital Inpatient Payment Adjustment. For county hospitals, defined as a county hospital in a county of over 3 million in population, the amount calculated pursuant to subsection (g)(2)(A) above shall be multiplied by 2.75.

j) Targeted Access Inpatient Payment Adjustment.

1) Targeted Access Hospitals (TAP) are defined as hospitals qualifying for disproportionate share under subsections (a)(1), (2), (3) and (4) above, that are reimbursed under 89 Ill. Adm. Code 148.240 through 148.300 or Part 149 or that meet at least one of the following criteria:

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A) The hospital is located in an urban area and has 500 or fewer beds as determined by the Illinois Department of Public Health; or

B) The hospital is located in a rural area and has 275 or fewer beds as determined by the Illinois Department of Public Health; or

C) The hospital is a children's hospital as defined in subsection (a)(4) above.

2) Targeted Access Inpatient Payment Adjustments are determined as follows:

A) Medicaid Percentage Adjustment. Targeted Access Hospitals, as defined in subsection (j)(1) above, shall receive an adjustment based upon their Medicaid inpatient utilization rate as defined in subsection (a)(1) above. Hospitals with a Medicaid inpatient utilization rate of 35% or above shall receive an adjustment of $70.00 per medical assistance admission in the targeted access base year and all other hospitals shall receive an adjustment per medical assistance admission in the targeted access base year which is calculated by dividing the individual hospital's Medicaid inpatient utilization rate by 35% and multiplying the result by $70.00.

B) Obstetrical Care Adjustment. Hospitals defined in subsection (j)(1)(A) and (B) that provide nonemergency obstetrical services and have complied with the requirements of subsection (b) above shall receive an Obstetrical Care Adjustment as follows:

i) an adjustment of $680.00 per medical assistance obstetrical admission in the targeted access base year; and

ii) an additional adjustment, up to $340.00 per medical assistance obstetrical admission in the targeted access base

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year, based upon the ratio of the hospital's obstetrical admissions to the obstetrical admissions provided by all targeted access hospitals (obstetrical percentage). The adjustment shall be calculated by giving the hospital providing the most obstetrical admissions a $340.00 adjustment per medical assistance obstetrical admission in the targeted access base year and all other qualifying hospitals an adjustment equal to the individual hospital's medical assistance obstetrical percentage divided by the obstetrical percentage of the hospital with the highest obstetrical percentage, the result of which shall then be multiplied by $340.00.

C) Children's Care Adjustment. All hospitals defined in subsection (j)(1) that provide services to children (defined as under the age of 18 and which excludes obstetrical services) shall receive a Children's Care Adjustment of up to $600.00 per medical assistance children's admission in the targeted access base year. The adjustment shall be calculated by dividing each hospital's medical assistance children's admissions in the targeted access base year by each hospital's total medical assistance admissions in the targeted access base year to arrive at the children's admission percentage. The hospital with the highest percentage of medical assistance children's admissions shall receive an adjustment of $600.00 for each medical assistance children's admission in the targeted access base year and all other qualifying hospitals shall receive an adjustment equal to $600.00 multiplied by the individual hospital's children's admission percentage divided by the children's admission percentage of the hospital with the highest children's admission percentage.

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D) Ambulatory Care Network Adjustment. Hospitals defined in subsection (j)(1)(A) and (B) shall complete and submit the Ambulatory Care Network Questionnaire in order to be considered for the Ambulatory Care Network Adjustment. To receive the Ambulatory Care Network Adjustment, eligible hospitals as defined in subsection (j)(1)(A) and (B) shall be required to enter into an agreement with the Department which describes in detail their involvements in ambulatory care, and includes commitments to maintain operations. The Ambulatory Care Network Adjustment shall consist of three (3) possible individual adjustments as follows:

i) Hospitals reporting the following number of physician office visits on the Ambulatory Care Network Questionnaire shall receive the following adjustments per total medical assistance admission in the targeted access base year:

Urban Threshold	Rural Threshold	Adjustment
0 - 9,999	0 - 4,999	$ 00.00
10,000 - 40,000	5,000 - 10,000	$125.00
40,001 - 100,000	10,001 - 50,000	$145.00
100,001 and over	50,001 and over	$165.00

ii) Hospitals qualifying for an adjustment under subsection (j)(2)(D)(i) above shall receive an additional $135.00 per total medical assistance admission in the targeted access base year if they have a formal linkage agreement with City of Chicago Partnerships in Health or Medicaid Partnerships.

iii) Hospitals qualifying for an adjustment under subsection (j)(2)(D)(i) above shall receive an additional $135.00 per total medical assistance admission in the targeted access base year if they

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have a formal linkage agreement with a Federally Qualified Health Center, a County Health Clinic, or a Rural Health Clinic.

3) Targeted Access Hospitals, as defined in subsection (j)(1) above, shall receive the applicable payment adjustment described in subsection (j)(2), in addition to any applicable adjustments described in subsections (g)(1), (g)(2), (h), (i), (k)(2) and (l)(2). The Targeted Access Payment Adjustments shall be paid to eligible hospitals on a quarterly basis.

k) Critical Care Access Inpatient Payment Adjustments

1) Critical Care Access Hospitals are those hospitals meeting one or more of the criteria described in subsection (a)(5) above.

2) Critical Access inpatient payment adjustments are determined as follows:

A) Level I Trauma Adjustment. Hospitals meeting the criteria defined in subsection (a)(5)(A) above shall receive an adjustment of $9,600.00 per medical assistance trauma admission in the critical care access base year.

B) Level II Rural Trauma Adjustment. Hospitals meeting the criteria defined in subsection (a)(5)(B) shall receive an adjustment of $9,400.00 per medical assistance trauma admission in the critical care access base year.

C) Level II Urban Trauma Adjustment. Hospitals meeting the criteria defined in subsection (a)(5)(C) shall receive an adjustment of $9,400.00 per medical assistance trauma admission in the critical care access base year.

D) Level II Rural Perinatal Adjustment. Hospitals meeting the criteria defined in

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subsection (a)(5)(D) shall receive an adjustment of $825.00 per medical assistance perinatal admission in the critical care access base year.

E) Rural Obstetrical Adjustment. Hospitals meeting the criteria defined in subsection (a)(5)(E) shall receive an adjustment of $675.00 per medical assistance obstetrical admission in the critical care access base year.

3) Hospitals qualifying as disproportionate share hospitals under subsections (a)(1), (2), (3) and (4) that also qualify as Critical Care Access Hospitals under subsection (a)(5) shall receive the applicable payment adjustments described in subsection (k)(2) in addition to any applicable adjustments described in subsections (g)(1), (g)(2), (h), (i), (j)(2) and (l)(2). The Critical Care Access payment adjustments shall be paid to eligible hospitals on a quarterly basis.

4) Hospitals that qualify as disproportionate share hospitals solely under subsection (a)(5) above shall not be eligible for any adjustments described in subsections (g) through (j). The Critical Care Access payment adjustments shall be in addition to any applicable adjustment described in subsection (l)(2) and shall be paid to eligible hospitals on a quarterly basis.

l) Disproportionate Share Uncompensated Care Payment Adjustment

1) The Department shall make disproportionate share uncompensated care payments to hospitals described in subsections (a)(1) through (a)(5) above that are reimbursed under 89 Ill. Adm. Code 148.170, 148.240 through 148.300 and Part 149.

2) For the period August 1, 1991 through July 31, 1992, the hospital's uncompensated care payment shall be calculated by multiplying the number of Medicaid days provided by the hospital in State

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Fiscal Year 1990 (and adjusted based upon historical utilization and projected increases in utilization) by $41.70. The hospital has the right to appeal this determination if it believes a technical error has been made in the calculation. The appeal must be in writing and must be received by the Department within 30 days of receipt of the first payment of the uncompensated care payment adjustment.

3) The Uncompensated Care payment adjustments shall be in addition to any applicable adjustments described in subsections (g)(1), (g)(2), (h), (i), (j)(2) and (k)(2) and shall be paid to eligible hospitals on a quarterly basis.

4) As a condition of eligibility for an uncompensated care payment adjustment during the August 1, 1991, uncompensated rate year, each hospital shall submit, on or before January 15, 1992, the following information to the Department for the period August 1, 1990 through July 31, 1991:

A) The dollar amount of uncompensated care charges rendered in the period described above.

B) The dollar amount of charges rendered during this period reimbursed by the Department under General Assistance (Article VI of the Public Aid Code) or Aid to the Medically Indigent (Article VII of the Public Aid Code).

C) The dollar amount of Medicaid charges rendered in the period described above.

D) The dollar amount of total charges for care rendered in the period described above.

5) As a condition of eligibility for an uncompensated care payment adjustment during uncompensated care rate years beginning August 1, 1992, and thereafter, each hospital shall

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annually submit, on or before October 1 of the uncompensated care rate year, the following information to the Department:

A) The dollar amount of uncompensated care charges rendered in the previous uncompensated care rate year.

B) The dollar amount of Medicaid charges rendered in the previous uncompensated care rate year.

C) The dollar amount of total charges for care rendered in the previous uncompensated care rate year.

6) The data submitted under (4) and (5) above shall be a statement for the uncompensated care rate year signed by the chief financial officer or chief executive officer certifying to the accuracy of the data submitted.

7) All hospitals required to submit cost reports in accordance with 89 Ill. Adm. Code 148.210(a) that provided Medicaid days in Fiscal Year 1990 shall be eligible for an uncompensated care payment adjustment for the uncompensated care rate year beginning August 1, 1991, subject to the reporting requirements of (4), (5) and (6) above.

8) A hospital will not be eligible for an uncompensated care payment adjustment under this Section for uncompensated care rate years beginning August 1, 1992, and thereafter, if the data supplied under (4), (5) and (6) above indicates a significant decrease in the level of uncompensated care. This determination will be made by comparing the level of uncompensated care provided in the immediately previous uncompensated care rate year to the level of uncompensated care provided in the base year of August 1, 1990, through July 31, 1991. For purposes of this determination, uncompensated care in the base year of August 1, 1990, through July 31, 1991, and in subsequent care rate years

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shall, in addition to its usual definition, include charges for services reimbursed by the Department under General Assistance (Article VI) and Aid to the Medically Indigent (Article VII). For example, eligibility for a payment for the uncompensated care rate year beginning August 1992 shall be subject to a determination that there is not a significant decrease in the level of uncompensated care provided from August 1991 through July 1992 as compared to the level of uncompensated care provided from August 1990 through July 1991. Factors which the Department may consider in determining whether a significant decrease in uncompensated care has occurred my include, but not be limited to, a change in socio-economic characteristics of the community.

9) Reimbursement for uncompensated care payment adjustments shall be made on a quarterly basis, payable to the hospital in the quarter following each quarter for which the hospital is entitled to an uncompensated care payment adjustment.

10) All hospitals eligible for an uncompensated care payment adjustment shall be deemed to have met the requirements of Section 5-17 of the Public Aid Code that hospitals provide equal access to available services to low-income persons who are eligible for assistance under Articles V, VI and VII of the Public Aid Code. Nothing in this subsection shall be construed to imply that a hospital that is ineligible for an uncompensated care payment adjustment has not met the requirements of Section 5-17 of the Public Aid Code.

~~g~~m) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:

1) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days,

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were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et. seq.) and the denominator of which is the total number of the hospital's inpatient days in that same period.

2) "Mean medical assistance inpatient utilization percentage" means the total number of medical assistance inpatient days provided by all Medicaid-participating hospitals divided by the total number of inpatient days provided by those same hospitals.

3) "Medicare utilization differential" means a hospital's Medicare inpatient utilization percentage minus the mean Medicare inpatient utilization percentage; provided, however, that in no event shall the Medicare utilization differential be less than zero.

4) "Medicare inpatient utilization percentage" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicare under Title XVIII of the federal Social Security Act, and the denominator of which is the total number of the hospital's inpatient days in that same period.

5) "Mean Medicare inpatient utilization percentage" means the total number of Medicare inpatient days provided by all Illinois hospitals divided by the total number of inpatient days provided by those same hospitals.

6) "Occupancy ratio" means a fraction, the numerator of which is the hospital's occupancy rate as determined by the Illinois Department of Public Health and the denominator of which is the mean occupancy rate of:

A) all Illinois hospitals located within Metropolitan Statistical Areas when calculating the occupancy ratio for a hospital located within a Metropolitan Statistical Area; or

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B) all Illinois hospitals located outside of Metropolitan Statistical Areas when calculating the occupancy ratio for a hospital located outside of any Metropolitan Statistical Area.

7) "Mean occupancy rate" means the sum of occupancy rates, as determined by the Illinois Department of Public Health, of all hospitals within a category of hospitals described in subsection (g)(6) divided by the total number of hospitals in such category.

8) "Children's admission" means a claim billed as an admission of an individual under the age of 18, which was subsequently paid by the Department, but excludes those claims billed as admissions with an ICD-9-CM principal diagnosis code within the range of 650 and 669 (indicating an obstetrical admission).

9) "Critical care access base year" means, State Fiscal Year 1990 for critical care access payments calculated for State Fiscal Year 1992; State Fiscal Year 1991 for critical care access payments calculated for State Fiscal Year 1993, etc.

10) "Medicaid charges" means hospital charges for services provided to recipients of medical assistance under Title XIX of the Social Security Act.

11) "Medicaid days" means hospital days billed and reimbursed by the Department for recipients of medical assistance under Title XIX of the Social Security Act.

12) "Obstetrical admission" means a claim billed as an admission, which was subsequently paid by the Department, with an ICD-9-CM principal diagnosis code within the ranges of 650 and 669 which result in childbirth.

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13) "Perinatal admission" means those claims billed as admissions, which were subsequently paid by the Department, for infants less than 29 days of age at the time of the admission with an ICD-9-CM diagnosis code within the ranges of 760 through 779 and V30 through V39, and those claims billed as admissions, which were subsequently paid by the Department, related to pregnancy, childbirth and the puerperium with an ICD-9-CM principal diagnosis code within the range of 630 through 676.

14) "Targeted access base year" means, State Fiscal Year 1990 for targeted access payments calculated for State Fiscal Year 1992; State Fiscal Year 1991 for targeted access payments calculated for State Fiscal Year 1993, etc.

15) "Total charges" means the total amount of a hospital's charges for services it has provided.

16) "Total medical assistance admissions" means the total claims billed as admissions which were subsequently paid by the Department.

17) "Trauma admission" means those claims billed as admissions, which were subsequently paid by the Department, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99. For those hospitals

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recognized as Level I trauma centers solely for pediatric trauma cases, trauma admissions are only calculated for the claims billed as admissions, which were subsequently paid by the Department, with ICD-9-CM diagnoses within the above ranges for children under the age of 18.

18) "Uncompensated care charges" for a hospital means:

A) the hospital's charges for services for which the hospital was not reimbursed by either the patient or a third party (including the Department);

B) less:

i) the amount of the hospital's bad debt recoveries for services; and

ii) the hospital's charges attributable to services that it provided without charge or at reduced charges under its obligation under the federal Hill-Burton Act (42 U.S.C. 291 et seq.).

19) "Uncompensated care rate year" means August 1 through July 31 of each year beginning with the August 1, 1991 rate year.

~~h) Payments to Participating Out of State Hospitals.--For purposes of the determination described in subsection (a)(1), out of state hospitals will be measured in relationship to the mean Medicaid inpatient utilization rate in their state.--Out of state hospitals which do not qualify by the Medicaid inpatient utilization rate from their state may submit a certified financial statement as described in subsection (d).--Payments to out of state hospitals will be allocated using the same method as described in subsection (e).~~

~~i) Time Limitation for Additional Information Requirements.--Beginning with state fiscal year 1991 ("FY 91") determinations for disproportionate share, submittal of information required in subsections (a)(2), (b), (c) and (d) must be received no later~~

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~~than June 30th of the state's fiscal year immediately preceding the fiscal year for which the hospital is requesting consideration of such information for the determination of disproportionate share qualification (i.e., for the FY 91 determination, information must be received no later than June 30, 1990).--Information required in subsections (a)(2), (b), (c) and (d) which is not received in compliance with these time limitations will not be considered for the determination of these hospitals qualified for disproportionate share payment adjustments.~~

~~j) Outlier Adjustments.--For inpatient services provided on or after July 1, 1989, the Department shall make outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for individuals under one year of age, when such services were provided by hospitals defined by the Department as disproportionate share under Section (a)(1) or (a)(2) of this rule.--The Department is not required to provide outlier adjustments for exceptionally long lengths of stay as there are no durational limits on inpatient stays and the Department reimburses the hospital on a per diem or per day basis regardless of the length of stay as long as such stay was medically necessary.--The determination of these services qualified for an outlier adjustment shall be made as follows:~~

~~1) The services must have been provided on or after July 1, 1989, to individuals under one year of age.~~

~~2) The services must have been provided by hospitals defined by the Department as disproportionate share under Sections (a)(1) or (a)(2) of this rule.~~

~~3) Claims with total covered charges equal to or above the mean total covered charges plus one standard deviation shall be considered for outlier adjustments once the following calculations have been performed:~~

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A) Total covered charges equal to or exceeding one standard deviation above the mean shall be multiplied by the hospital's cost to charge ratio.

B) The hospital's rate for services provided on the claim shall be multiplied by the number of covered days on the claim.

C) The product of (B) above shall be subtracted from the product of (A) above.

D) The difference of (C) above shall be multiplied by .25, the product of which shall be the outlier adjustment for the claim.

E) Third party liabilities shall be applied to the final payment made on the claim.

k) Definition of terms relating to outlier adjustments are as follows:

1) "Total covered charges" means the amount entered on the UB-82 Uniform Billing Form for revenue code 001 in column 53 (Total Charges), minus the amount in column 54 (Non-Covered Charges) for revenue code 001.

2) "Mean total covered charges" means the mean total covered charges (as described in (1) above) for all claims for inpatient services provided by the hospital to individuals under the age of one in the previous state fiscal year which have been paid by the Department.

3) "Cost to Charge Ratio" means the hospital's Medicaid total allowable cost for all care divided by the Medicaid total covered charges for all care. The Cost to Charge Ratio is derived by utilizing cost report data from the hospital's base fiscal year (i.e., calender year 1987 for fiscal year 1990 payments, calender year 1988 for fiscal year 1991 payments, etc.).

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4) "Rate for services provided" means the inpatient rate in effect for the type of services provided.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.130 Payment for Inpatient Services for GA Outlier Adjustments for Exceptionally Costly Stays

a) Non participating out of state hospitals (out of state hospitals providing fewer than 200 Illinois Medical Assistance days annually and not filing an Illinois Medicaid cost report) shall be paid by the Department by computing an average rate paid to Illinois hospitals and adjusting this amount for differing wage costs and differing costs associated with teaching hospitals subject to a limit of $500.00 per admission for inpatient services provided during the period July 1, 1983, through December 31, 1984. Inpatient services provided on or after January 1, 1985, shall be reimbursed according to provisions of Section 148.210.

b) Reimbursement to participating hospitals for claims for services provided prior to July 1, 1983, will be calculated and paid in accordance with the administative rules effective at the time the service was rendered.

c) Reimbursement to participating hospitals for inpatient services provided during the period beginning July 1, 1983, and ending December 31, 1984, shall be calculated and paid according to provisions of Sections 148.240 --- 148.330 subject to a limit of $500.00 per admission.

d) For GA clients residing in the City of Chicago, reimbursement to participating hospitals for inpatient services shall be in accordance with the Illinois Competitive Access and Reimbursement Equity (ICARE) Program, 89 Ill. Adm. Code 149.5 through 149.325.

e) For GA clients residing outside the City of Chicago, reimbursement to participating hospitals for inpatient-

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~~services shall be at the rate determined under ICARE for hospitals with an ICARE contract. However, if a hospital's ICARE rate would be less than the rate calculated under Sections 148.240 148.330, then that higher rate shall be utilized from the effective date of this Rule until the next ICARE contracting period for that area. If a hospital does not have an ICARE Contract, reimbursement to participating hospitals for inpatient services shall be calculated and paid according to the provision of Sections 148.240 148.330,~~

a) Outlier Adjustments. For inpatient services provided July 1, 1989 through June 30, 1991, the Department shall make outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for individuals under one year of age, when such services were provided by hospitals defined by the Department as disproportionate share under 89 Ill. Adm. Code 148.120(a)(1) through (a)(4). For inpatient services provided on or after July 1, 1991, the Department shall make outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for infants who have not attained the age of one (1) year, and to children who have not attained the age of six (6) years and who receive such services in a disproportionate share hospital described in 89 Ill. Adm. Code 148.120(a)(1) through (a)(5). The Department is not required to provide outlier adjustments for exceptionally long lengths of stay as there are no durational limits on inpatient stays and the Department reimburses the hospital on a per diem or per day basis regardless of the length of stay as long as such stay was medically necessary.

b) The determination of those services qualified for an outlier adjustment shall be made as follows for the period July 1, 1989 through June 30, 1991:

1) The services must have been provided on or after July 1, 1989, to individuals under one year of age.

2) The services must have been provided by hospitals

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defined by the Department as disproportionate share under 89 Ill. Adm. Code Sections 148.120(a)(1) through (a)(4).

3) Claims with total covered charges equal to or above the mean total covered charges plus one standard deviation shall be considered for outlier adjustments once the following calculations have been performed:

A) Total covered charges equal to or exceeding one standard deviation above the mean shall be multiplied by the hospital's cost to charge ratio.

B) The hospital's rate for services provided on the claim shall be multiplied by the number of covered days on the claim.

C) The product of (B) above shall be subtracted from the product of (A) above.

D) The difference of (C) above shall be multiplied by .25, the product of which shall be the outlier adjustment for the claim.

E) Third party payments (credits) shall be applied to the final payment made on the claim.

c) The determination of those services qualified for an outlier adjustment shall be made as follows for the period July 1, 1991 and after:

1) The services must have been provided on or after July 1, 1991.

2) The services must have been provided to:

A) children who have not attained the age of six (6) years by hospitals defined by the Department as disproportionate share under 89 Ill. Adm. Code 148.120(a)(1) through (a)(5); or

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B) infants who have not attained the age of one (1) year by hospitals that do not meet the definition of disproportionate share under 89 Ill. Adm. Code 148.120(a)(1) through (a)(5).

3) Claims with total covered charges equal to or above the mean total covered charges plus one standard deviation shall be considered for outlier adjustments once the following calculations have been performed:

A) Total covered charges equal to or exceeding one standard deviation above the mean shall be multiplied by the hospital's cost to charge ratio.

B) The hospital's rate for services provided on the claim shall be multiplied by the number of covered days on the claim.

C) The product of (B) above shall be subtracted from the product of (A) above.

D) The difference of (C) above shall be multiplied by .25, the product of which shall be the outlier adjustment for the claim.

E) Third party payments (credits) shall be applied to the final payment made on the claim.

d) The determination of those services qualified for an outlier adjustment shall be made as follows for admissions September 1, 1991 and after for hospitals and/or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with 89 Ill. Adm. Code 148.80(g):

1) The admission must have occurred on or after September 1, 1991; and

2) The services must have been provided to:

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A) children who have not attained the age of six (6) years by hospitals defined by the Department as disproportionate share under 89 Ill. Adm. Code 148.120(a)(1) through (a)(5); or

B) infants who have not attained the age of one (1) year by hospitals that do not meet the definition of disproportionate share under 89 Ill. Adm. Code 148.120(a)(1) through (a)(5).

3) Claims with total covered charges equal to or above the mean total covered charges plus one standard deviation shall be considered for outlier adjustments once the following calculations have been performed:

A) Total covered charges equal to or exceeding one standard deviation above the mean shall be multiplied by the hospital's cost to charge ratio.

B) The hospital's rate for services provided on the claim shall be multiplied by the number of covered days on the claim.

C) The product of (B) above shall be subtracted from the product of (A) above.

D) The difference of (C) above shall be multiplied by .25, the product of which shall be the outlier adjustment for the claim.

E) Third party payments (credits) shall be applied to the final payment made on the claim.

e) The determination of those services qualified for an outlier adjustment shall be made in accordance with 89 Ill. Adm. Code 149.105 for hospitals reimbursed on a per case basis.

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f) Definition of terms relating to outlier adjustments are as follows:

1) "Total covered charges" means the amount entered on the UB-82 Uniform Billing Form for revenue code 001 in column 53 (Total Charges), minus the amount in column 54 (Non-Covered Charges) for revenue code 001.

2) "Mean total covered charges" means the mean total covered charges (as described in (1) above) for all claims for inpatient services provided by the hospital to individuals under the age of one for services provided prior to July 1, 1991 and for services provided July 1, 1991 and after in non-disproportionate share hospitals and for individuals under the age of six for services provided July 1, 1991 and after in a disproportionate share hospital in the previous state fiscal year which have been paid by the Department.

3) "Cost to Charge Ratio" means the hospital's Medicaid total allowable cost for all care divided by the Medicaid total covered charges for all care. The Cost to Charge Ratio is derived by utilizing cost report data from the hospital's base fiscal year (i.e., calendar year 1987 for fiscal year 1990 payments, calendar year 1988 for fiscal year 1991 payments, etc.).

4) "Rate for services provided" means the inpatient rate in effect for the type of services provided.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.140 Hospital Outpatient and Clinic Services

a) Reimbursement for hospital outpatient and clinic services shall be made on a fee for service basis, except for those services that meet the definition of the Hospital Ambulatory Care Program as described in subsection (a)(3) and except as described in

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subsection (b) for ESRDT Services and subsection (c) for encounter rate hospitals.

1) Reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee for service.

2) Reimbursement for the fee codes established July 1, 1983, and implemented through March 31, 1986, for procedures performed in a hospital setting will be calculated and paid in accordance with the statutes and administrative rules governing the time period in question.

3) ~~Effective April 1, 1986, additional fee codes were established for outpatient procedures performed in a hospital setting. Procedures are grouped and reimbursed according to whether they are high level technology surgical procedures or other procedures. High Level Technology Surgical Procedures are those which either require general or spinal anesthesia or require any two of the following three criteria: the use of special equipment, a major surgical pack as opposed to a minor surgical pack, or longer than one hour of surgical time. High level technology surgeries will be reimbursed at the lower of actual charges or that hospital's inpatient contract rate (per diem rate for non contracting hospitals) equivalent to a one day inpatient stay. Other ambulatory surgical, specialized cardiac and diagnostic procedures are reimbursed at the lower of actual charges or the Department's designated payment maximum. Two groupings are used to establish the State maximums - major teaching and other hospitals. A major teaching hospital is one having four or more graduate medical-~~

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~~education programs---accredited by the American Medical Association, the American Dental Association or the American Osteopathic Association. The specialized treatment procedures, high risk and emergency room visits are reimbursed according to fiscal year 1986 payment methodology. Certain high level technology services recognized and approved by the Department as safe outpatient procedures are reimbursed in a category separate from other specialized cardiac and diagnostic procedures. This special category currently includes the following procedures: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (Cat Scan), and Cardiac Catheterization.~~ A Hospital Ambulatory Care list defines those technical procedures that require the use of the hospital outpatient setting, its technical staff and/or equipment. This list is updated periodically. The procedures are grouped according to type and complexity, each with a separate rate structure as follows:

A) High level technology surgeries are reimbursed at the lesser of charges or the hospital's alternate reimbursement rate equivalent to the rate of a one-day inpatient stay.

B) Other surgical, specialized cardiac and diagnostic procedures are reimbursed the lesser of charges or one of two separate rate maximums depending upon whether the hospital is classified as major teaching or other hospital. A major teaching hospital is one having four or more graduate medical eduation programs accredited by the American Medical Association, the American Dental Association or the American Osteopathic Association. This category will be reimbursed at the lesser of charges or a set rate maximum.

C) Certain nonsurgical, very high level technology services recognized and approved

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by the Department as safe outpatient procedures will be reimbursed in a category separate from other specialized cardiac and diagnostic procedures. This category will be reimbursed at the lesser of charges of one of two separate rate maximums depending upon whether the hospital is classified as major teaching or other hospital. A major teaching hospital is one having four or more graduate medical education programs accredited by the American Medical Association, the American Dental Assocation or the American Osteopathic Association. This category will be reimbursed at the lesser of charges or a set rate maximum.

D) Specialized treatment procedures, high risk, and emergency room services will be reimbursed at the lesser of charges or a set rate maximum, or one of two separate rate maximums depending upon whether the hospital is classified as major teaching or other hospital, or whether the service is provided in the outpatient or general clinic department. A major teaching hospital is one having four or more graduate medical education programs accredited by the American Medical Association, the American Dental Association or the American Osteopathic Association. This category will be reimbursed at the lesser of charges or a set rate maximum.

4) Reimbursement for encounter rate hospital outpatient and clinic services is on a fee for service basis except for those services that meet the definition of the Hospital Ambulatory Care programs and except for those services provided by an encounter rate hospital described in (B)(ii) below.

A) Effective July 1, 1990, encounter rate hospitals are defined as Illinois public hospitals that are located in a city with a population exceeding 1 million that have

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provided and have been paid for 85,000 days or more of inpatient hospital care to recipients of medical assistance during State Fiscal Year 1989.

B) Effective July 1, 1991, encounter rate hospitals are defined as:

i) Illinois county-owned hospitals located in a city with a population exceeding 3 million; or

ii) Illinois county-owned hospitals located in a city with a population exceeding 3 million that has provided and that has been paid for 85,000 days or more of inpatient hospital care to recipients of medical assistance during State Fiscal Year 1989.

C) Effective July 1, 1991, county-operated outpatient facilities are defined as Illinois county-operated outpatient facilities in a city with a population exceeding 3 million.

D) Effective September 1, 1991, encounter rate hospitals are defined as:

i) Illinois county-owned hospitals located in a city with a population exceeding 3 million; or

ii) Illinois county-owned hospitals located in a city with a population exceeding 3 million that has provided and that has been paid for 85,000 days or more of inpatient hospital care to recipients of medical assistance during State Fiscal Year 1989; or

iii) Illinois state-owned hospitals located in a city with a population exceeding 3 million.

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E) For encounter rate hospitals, a Hospital Ambulatory Care list defines those technical procedures that require the use of the hospital outpatient setting, its technical staff and/or equipment. This list is updated periodically. The procedures are grouped according to type and complexity, each with a separate rate structure as follows:

i) High level technology surgeries are reimbursed at the hospital's alternate reimbursement rate equivalent to the rate of a one-day inpatient stay.

ii) Other surgical, specialized cardiac and diagnostic procedures are reimbursed at one of two separate rate maximums depending upon whether the hospital is classified as major teaching or other hospital. A major teaching hospital is one having four or more graduate medical education programs accredited by the American Medical Association, the American Dental Association or the American Osteopathic Association.

iii) Certain nonsurgical, very high level technology services recognized and approved by the Department as safe outpatient procedures will be reimbursed in a category separate from other specialized cardiac and diagnostic procedures. This category will be reimbursed at one of two separate rate maximums depending upon whether the hospital is classified as major teaching or other hospital. A major teaching hospital is one having four or more graduate medical education programs accredited by the American Medical Association, the American Dental Association or the American Osteopathic Association.

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iv) Specialized treatment procedures, high risk, and emergency room services will be reimbursed at a set rate maximum, or one of two separate rate maximums depending upon whether the hospital is classified as major teaching or other hospital, or whether the service is provided in the outpatient or general clinic department. A major teaching hospital is one having four or more graduate medical education programs accredited by the American Medical Association, the American Dental Association or the American Osteopathic Association.

v) For an encounter rate hospital described in (B)(ii) above, all other outpatient and hospital-based clinic services are reimbursed at a set rate maximum.

F) For county-operated outpatient facilities, all outpatient services are reimbursed at a set rate maximum.

G) Encounter rate hospitals and county-operated outpatient facilities are required to submit outpatient cost reports to the Department within 90 days of the close of the hospital's fiscal year. The Department shall reconcile encounter rate hospital and county-operated outpatient facility reimbursement rates to actual cost based upon the hospitals' filed outpatient cost reports.

H) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located.

4~~)~~5) A list of restricted inpatient procedures pursuant to Section 148.180(b) ~~is~~has been established and is updated periodically. These

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restricted inpatient ~~these~~ procedures will only be reimbursed when performed outside the inpatient setting or when the hospital supplies justification for an inpatient admission that meets Departmental established criteria. These criteria include, but are not limited to:

A) Presence of medical conditions which make prolonged post-operative observations by a nurse or skilled medical personnel a necessity (e.g., heart disease, severe diabetes).

B) An unrelated procedure is being done simultaneously which itself requires surgical hospitalization.

C) The patient is unable to comprehend and/or follow the necessary instruction both prior to and following the procedure due to mental and/or physical impairment, and this would result in inadequate treatment and place the patient at risk.

D) Emergency admission or recent onset of severe symptoms would prohibit safely performing the procedure on an outpatient basis (e.g., bleeding, severe pain, nausea, vomiting).

E) Admission occurs subsequent to the performance of the procedure on an outpatient basis due to conditions such as:

i) instability of vital signs

ii) respiratory distress greater than existed pre-operatively

iii) post-operative pain not relieved by oral medication

iv) uncontrolled bleeding

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v) lack of state of consciousness appropriate to age and development

vi) presence of persistent nausea or vomiting

vii) inability to ambulate consistent with age, previous mobility status and/or procedure.

~~5) Reimbursement levels for additional fee codes that are eligible for payment pursuant to subsections (a)(3) and (4) will be at the lower of the hospital's actual charge or the Department's designated payment maximum. This payment shall be considered full and final payment for those procedures performed.~~

b) Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40~~(e)~~(a)(3) shall be made at the Department's payment rates, as follows:

1) For inpatient hospital services services provided pursuant to 148.40~~(e)(1)~~(a)(3)(A), the Department shall reimburse hospitals pursuant to Sections ~~148.200~~ 148.240 through ~~148.330~~ 148.300 and 89 Ill. Adm. Code 149.

2) For outpatient services or home dialysis treatments provided pursuant to Section 148.40~~(e)(2)~~(a)(3)(B) or ~~(3)~~(C), the Department will reimburse hospitals and clinics for ESRDT services at a rate which will reimburse the provider for the dialysis treatment and all related supplies and equipment, as defined in 42 CFR 405.231(o) (1984). This rate will be that rate established by Medicare pursuant to 42 CFR 405.439 and 405.441 (1989).

3) Payment for non-routine services. For services which are provided during outpatient or home dialysis treatment pursuant to Section 148.40~~(e)(2)~~(a)(3)(B) or ~~(3)~~(C) but are not defined as a routine service under 42 CFR

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405.231(o) (1989), separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code 140.430 through 140.434, 140.440 through 140.450, and 140.475 through 140.481, respectively.

4) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.

c) Reimbursement for hospital outpatient and clinic services provided by an encounter rate hospital on or after July 1, ~~1990~~ 1991, shall be made on an encounter rate basis.

1) Reimbursement levels shall be at ~~the lower of the~~ encounter rate hospital's ~~all inclusive charge as shown on the claim or the Department's encounter hospital specific reimbursement cost per~~ encounter rate for each of the procedure groups described in subsection (a)(3) and by the category of service as reported on a financial statement audited by an independent Certified Public Accountant. A Medicaid cost report detailing outpatient costs must be filed with the Department in accordance with the provisions that regulate the filing of hospital inpatient Medicare cost reports. These cost reports shall be used to calculate a cost based rate. Encounter rate hospitals will be required to bill the Department utilizing all-inclusive service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to encounter rate hospitals in the same manner as to non-hospital and hospital providers who bill fee-for-service.

2) Reimbursement for the fee codes defined in subsection (a)(3) for encounter rate hospitals will be reimbursed at the Department's rate calculated in subsection (c)(1) above.

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3) An encounter rate hospital is defined as an Illinois ~~public~~ county-owned, or effective September 1, 1991, an Illinois state-owned hospital~~:~~,

~~A)~~ located in a city with population exceeding ~~1~~ 3 million~~;~~, and

~~B) which provided and was paid for 85,000 days or more of inpatient hospital care to recipients of medical assistance during state fiscal year 1989;~~

4) Inpatient restricted procedures as provided in subsection (a)(4) shall apply to encounter rate hospitals.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.150 ~~Payment for Hospital Services During Fiscal Year 1982~~ Uncompensated Care Payment Adjustment for Nondisproportionate Share Hospitals

~~a) Reimbursement for hospital services which are payable from the Fiscal Year (FY) 1982 appropriation shall equal $843 million;~~

~~b) Reimbursement for services provided prior to October 1, 1981 and payable from the FY 1982 appropriation shall be calculated and paid according to the methodology in effect at the time the service was rendered;~~

~~c) Reimbursement for services provided after September 30, 1981, and payable from the FY 1982 appropriation shall be calculated and paid as follows:~~

~~1) The total amount available for payment for these hospital services from the FY 1982 appropriation shall be determined by subtracting, from the appropriation amount ($843 million), the following:~~

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~~A) the estimated amount for payments for services provided prior to October 1, 1981 and payable from the FY 1982 appropriation;~~

~~B) the estimated amount for payments for reconciliations normally payable during FY 1982;~~

~~C) the estimated amount for payment for cross over claims (days for which both Medicare and Medicaid will pay);~~

~~D) the estimated amount for payments for non hospital encounter rate clinics and;~~

~~E) an amount ($6.5 million) to be set aside for payments to hospitals pursuant to subsection (f) below.~~

~~2) A) The FY 1982 expected inpatient days, outpatient department visits and clinic visits for each individual hospital will be estimated. Each hospital will be notified of an initial estimate which will be based on the hospital's utilization experience during FY 1981. Each hospital may request (within seven days) that the initial estimate be revised because of changes which it anticipates in services to public aid clients during FY 1982. The Department will compare the total utilization for all of the hospitals' estimates to the Department's total estimated utilization for FY 1982. If the difference between the two estimates is less than 3% the Department will use the individual hospital's estimates of FY 1982 utilization. If the difference is greater than 3% the Department will calculate each hospital's expected utilization by multiplying the hospital's FY 1981 utilization experience times the ratio of expected statewide FY 1982 utilization to the statewide FY 1981 utilization.~~

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~~B) For new or significantly restructured hospitals for which FY 1981 data are not available, the Department will use the hospital's estimate of utilization modified as necessary according to experience with hospitals of similar size, location and service intensity.~~

~~3) A) An updated FY 1982 rate shall be calculated for each hospital. The updated rate is the hospital's final rate from its audited fiscal 1979 cost report updated from the midpoint of its fiscal 1979 cost report year to January 1, 1981 according to the index and methodology of the Data Resources Inc. national market basket price proxies, hospital inpatient general routine operating costs (DRI). Each hospital's updated rate will be equal to the final rate from its audited FY 1979 cost report, multiplied by the January 1, 1981 DRI and divided by the DRI for the midpoint of the hospital's FY 1979.~~

~~B) For new hospitals for which FY 1979 data are not available, the Department will use the most recent cost report on file for the hospital. If the hospital has not filed a cost report, the Department will use the hospital's estimate of rates, modified as necessary according to experience with hospitals of similar size, location and service intensity.~~

~~C) Hospitals which have significantly restructured since filing their FY 1979 cost report may submit a request, with supporting documentation, that the Department use more recent data. The request must be submitted no later than 30 days after the date the hospital is notified of its rate. The documentation submitted must indicate that the restructuring changes were mandated to meet state, federal or local health and safety standards, that the restructuring added or deleted at least 10 beds or 10% of the hospital's total bed capacity (whichever is less) or added or deleted a service category and that the hospital received a certificate of need, or that the hospital made other changes for which it received a certificate of need and that the changes required an expenditure of at least $150,000 and was of the type which must be capitalized according to normal accounting principles. Decisions on these requests shall be made within 60 days of receipt by the Department.~~

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~~4) Anticipated payments to each hospital shall be calculated by multiplying the hospital's expected utilization times its updated rate. If the total of the anticipated payments for all hospitals exceeds the amount available, an adjusted rate shall be calculated for each hospital by multiplying its updated rate times a percentage equal to the ratio of the total amount available under section 1 to the total anticipated payments, so that the payments do not exceed the limit.~~

~~5) A) If a hospital's proportion of medicaid days, as reported on the hospital's most recent cost report on file with the Department as of November 15, 1981, is greater than 25%,~~

~~B) The rate established by subsection (e)(4) above shall be increased by an amount equal to the product of:~~

~~i) the "percentage of reduction" (which is the difference between one (1.0) and the percentage established by operation of subsection (e)(4) above), multiplied by~~

~~ii) 3% for each percentage of medicaid utilization between 25% and 35% and by~~

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~~an additional 1% for each percentage of medicaid utilization greater than 35%.~~

~~C) If the estimated statewide savings produced by reducing the rates in subsection (e)(4) is less than 75% of the total amount to be saved by application of subsections (e)(3) and (e)(4), this rate shall be increased further so that any savings produced by calculation of the updated rate is reduced by the same factor as in (b).~~

~~6) The rates calculated in subsections (e)(4) and (e)(5) then shall be multiplied by the same percentage so as to establish rates which, when multiplied by the expected utilization, will produce anticipated expenditures equal to the amount available under subsection (e)(1).~~

~~7) A hospital may submit notice of any errors in the calculation of the rate to the Department within seven days of the date the hospital receives notice of the FY 1982 rate.~~

~~d) Hospitals must continue to submit claims for payment to the Department on a timely basis. The Department shall monitor the hospital's billing practices and audit as necessary to ensure the reduced expenditures reflect actual savings not delayed billings. If a hospital's billing pattern for FY 1982 varies from its FY 1981 billing pattern, the Department may consider that those bills which would have been submitted during FY 1982 if the hospital's billing pattern had not changed were submitted during FY 1982. Payment for bills considered submitted during FY 1982 will be calculated and made in accordance with this rule.~~

~~e) If at any time a hospital's utilization in FY 1982 exceeds its expected FY 1982 utilization (as calculated in subsection (e)(2) above), the Department may stop payment for the additional days/visits provided during fiscal year 1982. A hospital's utilization limits for inpatient days, outpatient department visits or clinic visits shall be revised upon a hospital's request, provided that the total payment to be made to that hospital for services during FY 1982 does not change. A hospital that stops receiving payment subsequently may receive additional payment under subsection (g).~~

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~~f) 1) Hospitals may request special consideration if implementation of this rule would create an extreme financial hardship and~~

~~A) at least 65% of the hospital's total inpatient days, as reported on the most recent cost report, were reimbursed under medicare, medicaid, general assistance, and aid to the medically indigent;~~

~~B) at least 20% of the hospital's total inpatient days, as reported on the most recent cost report, were reimbursed by medicaid;~~

~~C) the hospital will be unable to satisfy its reasonable and necessary cash flow requirements, based on accurate projections, as a result of the payment methodology described in this Section.~~

~~2) Any requests for special consideration must be submitted no later than 30 days after the date the hospital is notified of its rate.~~

~~3) The following documentation must be submitted with all requests for hardship consideration;~~

~~A) The most recent audited financial statement;~~

~~B) Any other financial and legal documents as would be necessary to establish that insufficient funds are legally available to meet cash flow requirements.~~

~~4) This documentation should include the following information for July 1, 1981 through June 30, 1982;~~

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A) Cash flow statement,

B) Revenue from non-hospital services,

C) Contributions,

D) Funded depreciation,

E) Unrestricted funds,

F) Grants

5) The Department will appoint a special advisory panel consisting of 5 members experienced in hospital financial matters.--The panel shall review all requests and may ask for additional documentation or information as necessary in order to recommend to the Department that special hardship consideration be granted or denied.--Decisions on these requests shall be made within 60 days of receipt by the Department.

6) Hospitals eligible for special consideration under this Section will receive an increase in their FY 1982 rates up to a maximum total increased payments for all hospitals of up to $6.5 million.---The relief shall be based on the lesser of the amount of the hospital's unmet cash flow requirements or the amount of the hospital's reduction in medicaid reimbursement as a result of this rule.--The rate increase shall be calculated by dividing the amount of the relief for the hospital by the expected units of service between September 30, 1981, and July 1, 1982.

g) If reimbursement for hospital services which are payable from the FY 1982 appropriation is less than $843 million, the Department shall increase payments to each hospital for these services prior to September 15, 1982.--If during FY 1982, the Department's review of expenditures for hospital services indicates that the fiscal year expenditures will be less than $843 million, the utilization limits for a hospital under subsection (e) may be revised or rates established

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Section 148.150 Payment for Hospital Services During Fiscal Year 1982 Uncompensated Care Payment Adjustment for Nondisproportionate Share Hospitals (Cont'd)

under subsection (e) may be increased.--Any funds remaining after payment of all claims payable from the FY 1982 appropriation, will be distributed to hospitals which stopped receiving payment under subsection (e) because they exceeded their expected days/visits as a result of circumstances clearly beyond the hospital's control, such as increased referrals from other hospitals.--The remainder of the $843 million will be apportioned among inpatient, outpatient, and clinic services according to the proportion of the Department's spending among these services in FY 1982.--These funds will then be distributed among hospitals according to each hospital's proportionate share of the Department's spending for services provided during FY 1982 and payable during FY 1982.

h) In no case may a hospital's rates be at a level which would produce reimbursement in excess of the amount the hospital would receive under the Medicare principles of reimbursement in effect during the period covered by this rule.

i) Payments to hospitals for services provided after June 30, 1981 and payable from the FY 1982 appropriation shall be reconciled to each hospital's actual allowable costs, in accordance with Department rules, provided that:

1) the total amount expended for all reconciliations during FY 1983 shall not exceed $84 million,

2) no portion of the estimated FY 1982 $106 million savings shall be considered a reconcilable cost, and

3) the total amount expended for reconciliations for services provided between July 1, 1981 and June 30, 1982 shall not exceed $88 million.

j) While this Section is in effect, none of the following shall apply:--copayments for hospital outpatient and clinic services;--copayments for physician's services;--dollar limits for inpatient hospital services related

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~~to selected surgical procedures; the requirement that certain surgical procedures, when medically appropriate, not be performed on an inpatient basis; and limits on preoperative days for inpatient surgery or diagnostic testing.~~

~~k) 1) The provisions of this rule shall be in effect during FY 1982 for so long as the Director of the Department finds that:~~

~~A) The total number of hospitals agreeing to be reimbursed pursuant to the provisions of this rule is sufficient to assure that medical assistance recipients have reasonable access to hospital services.~~

~~B) The provisions are approved by the Department of Health and Human Services in the State Title XIX Plan.~~

~~C) The Department has not been enjoined, restrained or otherwise delayed or prohibited by Court order or actions of entities other than the Department from enforcing the provisions.~~

~~2) If any of the conditions in subsection (k)(1) fail to occur, limitations in subsection (j) shall be enforced and alternative service coverage and reimbursement limitations shall be implemented to assure that payments for hospital services during FY 1982 will be approximately the same as would have been made under this rule.~~

~~l) Hospitals may be exempted from the provisions of this rule if they submit an alternative methodology which is acceptable to the Director and results in an expenditure which does not exceed the expenditure to be made under this rule.~~

a) The Department shall make uncompensated care payments to hospitals that do not qualify for disproportionate share under 89 Ill. Adm. Code Sections 148.120(a)(1) through (a)(5) that are reimbursed under 89 Ill. Adm. Code 148.170, 148.240 through 148.300 or Part 149.

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Section 148.150 ~~Payment for Hospital Services During Fiscal Year 1982~~ Uncompensated Care Payment Adjustment for Nondisproportionate Share Hospitals (Cont'd)

b) For the period August 1, 1991 through July 31, 1992, the hospital's uncompensated care payment shall be calculated by multiplying the number of Medicaid days provided by the hospital in State Fiscal Year 1990 (and adjusted based upon historical utilization and projected increases in utilization) by $41.70. The hospital has the right to appeal this determination if it believes a technical error has been made in the calculation. The appeal must be in writing and must be received by the Department within 30 days of receipt of the first payment of the uncompensated care payment adjustment.

c) The Uncompensated Care payment adjustments shall be in addition to any applicable adjustments described in subsections (g)(1), (g)(2), (h), (i), (j)(2) and (k)(2) and shall be paid to eligible hospitals on a quarterly basis.

d) As a condition of eligibility for an uncompensated care payment adjustment during the August 1, 1991, uncompensated rate year, each hospital shall submit, on or before January 15, 1992, the following information to the Department for the period August 1, 1990 through July 31, 1991:

1) The dollar amount of uncompensated care charges rendered in the period described above.

2) The dollar amount of charges rendered during this period reimbursed by the Department under General Assistance (Article VI of the Public Aid Code) or Aid to the Medically Indigent (Article VII of the Public Aid Code).

3) The dollar amount of Medicaid charges rendered in the period described above.

4) The dollar amount of total charges for care rendered in the period described above.

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Section 148.150 ~~Payment for Hospital Services During Fiscal Year 1982~~ Uncompensated Care Payment Adjustment for Nondisproportionate Share Hospitals (Cont'd)

e) As a condition of eligibility for an uncompensated care payment adjustment during uncompensated care rate years beginning August 1, 1992, and thereafter, each hospital shall annually submit, on or before October 1 of the uncompensated care rate year, the following information to the Department:

1) The dollar amount of uncompensated care charges rendered in the previous uncompensated care rate year.

2) The dollar amount of Medicaid charges rendered in the previous uncompensated care rate year.

3) The dollar amount of total charges for care rendered in the previous uncompensated care rate year.

f) The data submitted under (d) and (e) above shall be a statement for the uncompensated care rate year signed by the chief financial officer or chief executive officer certifying to the accuracy of the data submitted.

g) All hospitals required to submit cost reports in accordance with 89 Ill. Adm. Code 148.210(a) that provided Medicaid days in Fiscal Year 1990 shall be eligible for an uncompensated care payment adjustment for the uncompensated care rate year beginning August 1, 1991, subject to the reporting requirements of (d), (e) and (f) above.

h) A hospital will not be eligible for an uncompensated care payment adjustment under this Section for uncompensated care rate years beginning August 1, 1992, if the data supplied under (d), (e) and (f) above indicates a significant decrease in the level of uncompensated care. This determination will be made by comparing the level of uncompensated care provided in the immediately previous uncompensated care rate year to the level of uncompensated care provided in the base year of August 1, 1990, through July 31, 1991. For purposes of this determination,

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Section 148.150 ~~Payment for Hospital Services During Fiscal Year 1982~~ Uncompensated Care Payment Adjustment for Nondisproportionate Share Hospitals (Cont'd)

uncompensated care in the base year of August 1, 1990, through July 31, 1991, and in subsequent uncompensated care rate years shall, in addition to its usual definition, include charges for services reimbursed by the Department under General Assistance (Article VI) and Aid to the Medically Indigent (Article VII). For example, eligibility for a payment for the uncompensated care rate year beginning August 1992 shall be subject to a determination that there is not a significant decrease in the level of uncompensated care provided from August 1991 through July 1992 as compared to the level of uncompensated care provided from August 1990 through July 1991. Factors which the Department may consider in determining whether a significant decrease in uncompensated care has occurred may include, but not be limited to, a change in socio-economic characteristics of the community.

i) Reimbursement for uncompensated care payment adjustments shall be made on a quarterly basis, payable to the hospital in the quarter following each quarter for which the hospital is entitled to an uncompensated care payment adjustment.

j) All hospitals eligible for an uncompensated care payment adjustment shall be deemed to have met the requirements of Section 5-17 of the Public Aid Code that hospitals provide equal access to available services to low-income persons who are eligible for assistance under Articles V, VI and VII of the Public Aid Code. Nothing in this subsection shall be construed to imply that a hospital that is ineligible for an uncompensated care payment adjustment has not met the requirements of Section 5-17 of the Public Aid Code.

k) Definitions

1) "Medicaid charges" means hospital charges for services provided to recipients of medical assistance under Title XIX of the Social Security Act.

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2) "Medicaid Days" means hospital days reimbursed by the Department for recipients of medical assistance under Title XIX of the Social Security Act.

3) "Total charges" means the total amount of a hospital's charges for services it has provided.

4) "Uncompensated care charges" for a hospital means:

A) the hospital's charges for services for which the hospital was not reimbursed by either the patient or a third party (including the Department);

B) less:

i) the amount of the hospital's bad debt recoveries for services; and

ii) the hospital's charges attributable to services that if provided without charge or at reduced charges under its obligation under the federal Hill-Burton Act (42 U.S.C. 291 et seq.).

5) "Uncompensated care rate year" means August 1 through July 31 of each year beginning with August 1, 1991 rate year.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million

~~Inpatient, outpatient and clinic services~~

~~a) Reimbursement for hospital services which are payable from the fiscal year 1983 appropriation shall not exceed the amount appropriated for hospital~~

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Section 148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~expenditures.~~

~~b) Reimbursement for claims for services provided after October 1, 1981 and prior to July 1, 1982 shall be paid at the interim rates calculated in accordance with Section 148.150. These payments shall be reconciled in accordance with provisions in Section 148.150.~~

~~c) Reimbursement for services provided on or after July 1, 1982 and payable from the fiscal year 1983 appropriation shall be calculated and paid as follows:~~

~~1) The total amount available for payment for these hospital services from the fiscal year 1983 appropriation shall be determined by subtracting from the appropriation amount the following:~~

~~A) an amount ($84 million) for payments for reconciliations normally payable during fiscal year 1983;~~

~~B) an estimated amount for payments for non-hospital encounter rate clinics;~~

~~C) an estimated amount for payments for Medicare cross over claims (hospital services which are reimbursed by Medicare for which Medicaid pays the coinsurance and deductible amounts);~~

~~D) an estimated amount for interim payments for services provided prior to July 1, 1982; and~~

~~E) an amount ($15.5 million) to provide relief for certain hospitals which experience financial hardship because they serve a disproportionate number of low income patients or Medicare patients (under subsection (c) of this Section) and to adjust rates for certain hospitals which have significantly restructured since filing their base year cost report (under subsection (f) of this Section).~~

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Section 148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~2) Fiscal year 1983 inpatient days, outpatient department visits and clinic visits for each hospital will be estimated in accordance with Section 148.170. This estimate will be the total allowable covered service units for the hospital.~~

~~3) A) An updated rate will be calculated for each hospital, using the hospital's most recent cost report on file with the State or the fiscal intermediary on December 31, 1981.~~

~~B) The updated rate is the hospital's computed rate from its base year cost report updated from the midpoint of the year to January 1, 1983 according to the index and methodology of the Data Resources Inc. national market basket price proxies, hospital inpatient general routine operating costs (DRI).~~

~~C) If the cost report used as a basis for the rate calculation under this section is subsequently audited and adjusted, the hospital's rate will be recalculated using the computed rate after audit. For any claims which have been processed, the Department will make adjustments to payments.~~

~~D) For new hospitals for which a cost report is not on file, the Department will use the hospital's estimate of rates, adjusted as necessary according to experience with hospitals of similar size, location and service intensity.~~

~~4) Expected payments to each participating hospital shall be calculated by multiplying its expected number of inpatient days, outpatient department visits and clinic visits (estimated in subsection (e)(2)) by the inpatient per diem, outpatient department per visit rate and clinic per visit rate (calculated in subsection (e)(3)).~~

~~5) If the total of the expected payments for all participating hospitals (under subsection (e)(4) exceeds the amount available (under subsection (e)(1), the rates shall be adjusted so that expenditures do not exceed the limit.~~

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Section 148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~6) The ratio of the total amount available (under subsection (e)(1) above to the total expected payments (under subsection (e)(4) above) will be calculated and that ratio will be multiplied by each hospital's updated rate to determine the adjusted rate for inpatient, outpatient and clinic services.~~

~~7) To provide special relief to hospitals serving a disproportionately high volume of Medicaid patients, the rate established by subsection (e)(6) will be increased by an amount equal to 3% of the reduction for each percent of Medicaid utilization between 25% and 35% Medicaid, plus 1% for each 1% over 35% Medicaid. To determine a hospital's proportion of medicaid days, the hospital's cost report on file with the Department as of March 1, 1982, will be used.~~

~~8) To assure that total expected payments do not exceed the amount available, the rates calculated in (e)(6) and (e)(7) will be multiplied by the ratio of the total amount available to total expected payments (at rates under subsections (e)(6) and (e)(7) above). This shall be the hospital's interim rate for inpatient days and outpatient department and clinic visits.~~

~~d) Hospitals shall be notified of their rates for fiscal year 1983 and shall have an opportunity to request a review of the rates for:~~

~~1) errors in calculating the rate (such a request must be submitted to the Department within 14 days of the date of the Department's notice to the Hospitals of the rates);~~

~~2) severe cash flow problems in accordance with section (e). (such a request must be submitted within 45 days of the date of the notice of the-~~

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Section 148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~documentation requirements);~~

~~3) significant restructuring since filing the base year cost report in accordance with section (f). (such a request must be submitted within 45 days of the date of the notice of the documentation requirements).~~

~~e) 1) Any hospital that serves a disproportionate number of low income and Medicare patients and which has insufficient funds available to meet its reasonable and necessary cash flow requirements as a result of this payment methodology may request special consideration.~~

~~2) The following documentation must be submitted with all requests for hardship consideration:~~

~~A) The most recent audited financial statement;~~

~~B) An estimated financial statement for June 30, 1982;~~

~~C) Any other financial and legal documents as would be necessary to establish that insufficient funds are legally available to meet cash flow requirements, including the following information for July 1, 1982 through June 30, 1983:~~

~~i) projected monthly cash flow statement.~~

~~ii) projected income statement.~~

~~iii) projected balance sheet.~~

~~iv) projected statement of changes in fund balance.~~

~~v) projected statement of changes in financial position.~~

~~vi) fiscal year 1982 budget.~~

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~~D) These documents must address revenue from non hospital services, contributions, funded depreciation, unrestricted funds, and grants.~~

~~E) Any documentation requested by the panel reviewing the request which is necessary to establish eligibility.~~

~~F) Any cost report which has been filed by the hospital after March 1, 1982, but before September 1, 1982, which the hospital wants the Department to consider which shows the hospital's percentage medicare, medicaid, GA or AMI.~~

~~G) Any documentation which the hospital wants the Department to consider which shows what amount of the hospital's unmet cash flow requirement has been caused by this reimbursement methodology.~~

~~3) The Department will appoint a special advisory panel consisting of individuals experienced in hospital administration and governance and hospital finance. The panel shall review all requests and may ask for additional documentation or information as necessary to recommend to the Department that hardship relief be granted or denied.~~

~~4) To qualify, a hospital must serve a disproportionate number of low income and medicare patients and have insufficient funds available to meet its reasonable and necessary cash flow requirements. Hospitals which qualify will receive an increase to their rate calculated in section e above, based on the lesser of the hospital's unmet cash flow requirements or the amount of reduction in reimbursement under this rate methodology. For any claims for services rendered after June 30, 1982, which have been processed by the Department prior to the date the rate change under this subsection is implemented, a cash payment shall be made by the Department.~~

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Section 148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~for the rate difference for those services.~~

~~f) Hospitals which have significantly restructured since filing their base year cost report may submit a request, with supporting documentation, that the Department use more recent data.~~

~~1) To qualify, the documentation submitted must indicate:~~

~~A) that the restructuring changes were mandated to meet state, federal or local health and safety standards; or,~~

~~B) that the restructuring added or deleted at least 10 beds or 10% of the hospital's total bed capacity (whichever is less), or added or deleted a service category (as defined in the Illinois Health Facilities Planning Act (IHFPA)), and that the hospital received a certificate of need; or,~~

~~C) that the hospital made other capital changes for which it received a certificate of need; and~~

~~D) that its unit costs have risen by at least one percent as a direct result of mandated changes to meet Federal, State or local health and safety standards under subsection (f)(1)(A); or that its unit costs have risen by at least five percent as a direct result of significant changes in physical plant or other changes under subsection (f)(1)(A), (B), and/or (G). To establish the percentage unit cost increase, the unit costs attributable to restructuring for the given time period will be divided by the total unit costs for the same time period~~

~~2) Hospitals which qualify will have their base year unit costs adjusted and their interim rate recalculated. For any claims for services rendered after June 30, 1982, which have been~~

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~~processed by the Department prior to the date the rate change under this subsection is implemented, a cash payment shall be made by the Department for the rate difference for those services.~~

~~g) If the 15.5 million relief fund is inadequate to satisfy the valid claims of all hospitals, the funds shall be distributed as follows:~~

~~1) First to hospitals experiencing financial hardship which~~

~~A) Have at least 65% of their total inpatient days reimbursed under Medicare, Medicaid, General Assistance and Aid to the Medically Indigent, and at least 20% of their total inpatient days reimbursed by Medicaid; or~~

~~B) Have at least 35% of their total inpatient days reimbursed by Medicaid; or~~

~~C) receive interim payments under Medicaid, GA, and AMI, of at least 6% of the Department's total estimated fiscal year 1983 payments to hospitals and to hospitals which have restructured under subsection f.~~

~~2) Second to any other hospital documenting a financial hardship under subsection (e).~~

~~3) If there are not sufficient funds to provide relief to all eligible hospitals in either of the groups, each hospital in the group will receive the percentage of the remaining dollars which equals the ratio of its amount of approved relief to the total amount of approved relief for all hospitals in that grouping.~~

~~h) Any hospital which requests a review under subsection (d) shall be notified of the results of the review no later than November 15, 1982.~~

~~i) Hospitals must continue to submit claims for payment to the Department on a timely basis. The Department~~

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Section 148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~shall monitor the hospitals' billing practices and audit as necessary to ensure the reduced expenditures reflect actual savings and not delayed billings. The Department shall consider a claim as payable during fiscal year 1983, if the claim was paid between July 1, 1982 and June 30, 1983, or would have been paid during that time if the billing cycles and payment cycles were the same on June 30, 1983, as they were on June 30, 1982.~~

~~j) If a hospital's utilization in FY 1983 exceeds its estimated utilization (as calculated in Section e(2) above), or if it appears to a hospital that it will in the near future exceed its utilization limits for inpatient days, outpatient department visits or clinic visits, these limits may be revised provided that the total payment to be made for hospital services during FY 1983 does not change. If a hospital exceeds its FY 1983 utilization limits for the additional days/visits provided during fiscal year 1983, the Department may stop payments for those days/visits.~~

~~k) The Department shall spend 797.5 million during the twelve month period July 1, 1982, through June 30, 1983.~~

~~1) Interim payments to hospitals for services rendered to Medicaid recipients between July 1, 1982 and June 30, 1983, shall be reconciled to each hospital's rate as calculated in subsection (e) above provided that:~~

~~A) the total amount expended for all reconciliations during fiscal year 1984 shall not exceed $170 million.~~

~~B) the total amount expended for reconciliations for services provided between July 1, 1982, and June 30, 1983, shall not exceed $178 million.~~

~~2) If reconciliation payments would exceed the limitations in subsection 1, the Department will pay all hospitals a percentage of the reconciliation payment. If the percentage is revised subsequently, reconciliation payments already made shall be adjusted. The Department shall either spend $170 million for reconciliation payments or reconcile up to each hospital's rate calculated in subsection (e).~~

~~3) Preliminary settlement for reconciliation shall be made on or before July 15, 1983, or 60 days after a hospital files its cost report covering fiscal year 1983 services, whichever is later. Final settlement shall be made on or before July 15, 1983 or 90 days after the cost report is filed, whichever is later.~~

~~4) Any services rendered in excess of a hospital's utilization limits shall not be reconciled.~~

~~m) The provisions of this Section shall be in effect during fiscal year 1983 for so long as the Director of the Department finds that:~~

~~1) The total number of hospitals agreeing to be reimbursed pursuant to the provisions of this rule is sufficient to assure that medical assistance recipients have reasonable access to hospital services.~~

~~2) The provisions are approved by the Department of Health and Human Services in the State Title XIX Plan.~~

~~3) The Department has not been enjoined, restrained or otherwise delayed or prohibited by Court order or actions of entities other than the Department from enforcing the provisions.~~

~~4) If any of the conditions specified above fail to occur, alternative service coverage and reimbursement limitations shall be implemented to assure that payments for hospital services during fiscal year 1983 will be approximately the same as would have been made under this rule.~~

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Section 148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

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Section 148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~n) Hospitals may be exempted from the provisions of this rule if they submit an alternative methodology which is aeeeptable to the Director and results in an expenditure which does not exeeed the expenditure which would otherwise be made under this rule.~~

a) In accordance with 89 Ill. Adm. Code 149.50 (c)(8), county-owned hospitals in a county with a population greater than three million are excluded from the DRG PPS and are reimbursed in accordance with this section.

b) Base Year Costs

1) Each hospital's base year operating costs shall be the Medicaid cost per diem contained in the hospital's audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospitals fiscal years ending between 19 and 30 months prior to the fiscal year for which rates are being set (i.e., calendar year 1989 for fiscal year 1992 rates, calendar year 1990 for fiscal year 1993 rates, etc.).

2) Each hospital's base year capital related costs shall be derived from the same audited cost report used for operating costs in subsection (b)(1) above.

3) Each hospital's base year direct medical education costs shall be derived from the same audited cost report used for operating costs in subsection (b)(1) above.

4) Each hospital's base year costs shall be the sum of the hospital's operating costs, capital related costs and medical education costs defined in subsections (b)(1) through (b)(3).

5) For new hospitals for which a base year cost report is not on file, the Department will use a more recently filed cost report, or if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate based on a rate estimated as soon as a cost report becomes available. The recalculated rate will be effective for the entire fiscal year and the Department will retroactively adjust payments if reported costs are not consistent with the estimate on which the payments are based.

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Section 148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

c) Restructuring Adjustments

Adjustments to base year costs will be made to reflect restructuring since filing the base year cost report. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost report available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost report to determine restructuring costs. If an audited cost report becomes available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Finance Section, Illinois Department of Public Aid, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Finance Section between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the report is received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year costs.

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Section 148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

d) Inflation Adjustment For Base Year Cost Report Inflator

Base year costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set (rate year) according to the hospital's historical rate of annual cost increases, as measured by dividing the hospital's cost report cost per diem as defined in subsection (b)(1) above by the previous year's cost report cost per diem.

e) Review Procedure

The review procedure shall be in accordance with 89 Ill. Adm. Code 148.310.

f) Applicable Adjustments for Disproportionate Share Hospitals

1) The criteria and methodology for making applicable adjustments to disproportionate share hospitals which are exempt from the DRG PPS as described in subsection (a) above, shall be in accordance with 89 Ill. Adm. Code 148.120.

2) In addition to the disproportionate share hospital payment adjustments described in 89 Ill. Adm. Code 148.120, hospitals reimbursed under this Section shall have supplemental disproportionate share payments calculated by multiplying the sum of the hospital's base year costs plus disproportionate share payment adjustments per diem from 89 Ill. Adm. Code 148.120 by the hospital's percentage of inpatient days which are not reimbursed by a third party payer.

g) Outlier Adjustments

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving

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Section 148.160 ~~Payment for Hospital Services During Fiscal Year 1983~~ Payment Methodology for County-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

exceptionally high costs for certain individuals shall be made in accordance with 89 Ill. Adm. Code 148.130.

h) Reductions to Total Payments

1) Copayments. Copayments are assessed under all medical programs administered by the Department except the General Assistance Program and shall be assessed in accordance with 89 Ill. Adm. Code 148.190.

2) Third Pary Payments. The requirements of 89 Ill. Adm. Code 149.290(c)(2) shall apply.

i) Prepayment and Utilization Review

Prepayment and utilization review requirements shall be in accordance with 89 Ill. Adm. Code 148.240.

j) Cost Reporting Requirements

Cost reporting requirements shall be in accordance with 89 Ill. Adm. Code 148.210.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million

~~a) The Department will establish limits on the allowable inpatient days for every participating hospital. It will do so by comparing the past length of stay performance of individual hospitals with that of other hospitals for the same or related diagnoses.~~

~~1) The primary diagnosis groupings will consist of all individual diagnosis codes or related groups of codes with more than 500 admissions from October 1980 through September 1981 which were paid between October 1980 and March 1982. All~~

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Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~remaining diagnosis codes will be grouped according to the 83 primary diagnosis groups developed by Yale University, as reported in Autogrp: Patient Classification Scheme and Diagnosis Related Groups, Health Care Financing Administration, except that whenever fewer than 500 claims are attributable to one of these groups, that group will be combined with one or more related groups to ensure that no primary diagnosis group will represent fewer than 500 admissions.~~

~~2) Following is a list of the primary diagnosis groups:~~

~~Intestinal infectious diseases,~~

~~Other bacterial diseases,~~

~~Viral diseases,~~

~~Other infectious and parasitic diseases,~~

~~Malignant neoplasm of digestive system,~~

~~Malignant neoplasm of respiratory system,~~

~~Malignant neoplasm of skin or breast,~~

~~Malignant neoplasm, genitourinary system,~~

~~Malignant neoplasm, other & unspecified,~~

~~Malignant neoplasm of lymphatic/hemopoietic tissue,~~

~~Benign neoplasm of female genital organ,~~

~~Benign neoplasm of male genital organs,~~

~~Benign neoplasm of other sites,~~

~~Carcinoma in situ of digestive organs, respiratory system, skin, breast,~~

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Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~genitourinary system, and other and unspecified sites,~~

~~Other neoplasms,~~

~~Disorders of thyroid gland,~~

~~Diabetes mellitus without complication,~~

~~Diabetes mellitus with complication,~~

~~Disorders of parathyroid gland,~~

~~Diseases of other endocrine glands,~~

~~Nutritional and other metabolic and immunity disorders,~~

~~Fluid volume depletion,~~

~~Sickle cell anemia,~~

~~Other and unspecified anemias,~~

~~Other diseases of blood and blood forming organs,~~

~~Paranoid schizophrenia,~~

~~Other or unspecified schizophrenic disorders,~~

~~Major depressive disorder, single episode,~~

~~Other affective psychoses,~~

~~Other psychoses not attributed to physical conditions,~~

~~Anxiety states,~~

~~Neurotic depression,~~

~~Other neuroses,~~

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Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~Alcoholic psychoses,~~

~~Acute alcoholic intoxification,~~

~~Other and unspecified alcohol dependence,~~

~~Other mental disorders,~~

~~Depressive disorder, NEC,~~

~~Inflammatory, hereditary, and degenerative diseases of the central nervous system,~~

~~Other paralytic syndromes,~~

~~Epilepsy,~~

~~Other disorders of the central nervous system,~~

~~Disorders of the peripheral nervous system,~~

~~Cataract,~~

~~Strabismus and other disorders of binocular eye movement,~~

~~Other disorders of eye and adnexa,~~

~~Nonsuppurative otitis media and Eustachian tube disorders,~~

~~Suppurative and unspecified otitis media,~~

~~Other disorders of ear and mastoid process,~~

~~Essential hypertension,~~

~~Other hypertensive disease,~~

~~Acute myocardial infarction,~~

~~Angina pectoris,~~

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Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~Coronary atherosclerosis,~~

~~Other ischemic heart disease,~~

~~Cardiac dysrhythmias and conduction disorders,~~

~~Heart failure,~~

~~Carditis, valvular, & other heart diseases,~~

~~Acute, ill defined, cerebrovascular disease,~~

~~Other cerebrovascular disease,~~

~~Diseases of arteries, arterioles, and capillaries~~

~~Other Diseases of vascular system,~~

~~Diseases of pulmonary circulation,~~

~~Phlebitis & thrombophlebitis,~~

~~Hemorrhoids,~~

~~Acute tonsillitis,~~

~~Chronic tonsillitis,~~

~~Hypertrophy and other diseases of tonsils and adenoids,~~

~~Croup,~~

~~Other acute URI & influenza,~~

~~Other diseases of upper respiratory tract,~~

~~Pneumococcal pneumonia,~~

~~Bronchopneumonia,~~

~~Pneumonia, other,~~

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Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~Acute bronchitis,~~

~~Acute bronchiolitis,~~

~~Bronchitis, other,~~

~~Asthma,~~

~~Other diseases of respiratory tract,~~

~~Chronic airway obstruction, NEC,~~

~~Dental caries,~~

~~Other diseases of oral cavity, salivary glands & jaws,~~

~~Duodenal ulcer,~~

~~Other gastric & peptic ulcers,~~

~~Diseases of esophagus,~~

~~Acute gastritis,~~

~~Other or unspecified gastritis and duodenitis,~~

~~Other upper GI tract diseases,~~

~~Acute appendicitis with peritonitis,~~

~~Acute appendicitis without peritonitis,~~

~~Appendicitis, other or unqualified,~~

~~Inguinal hernia without obstruction or gangrene,~~

~~Umbilical hernia without obstruction or gangrene,~~

~~Other hernia of abdominal cavity,~~

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~Enteritis, diverticula, & functional disorder of intestine,~~

~~Other & unspecified noninfectious gastroenteritis & colitis,~~

~~Functional digestive disorders, NEC,~~

~~Diseases of anus,~~

~~Intestinal obstruction without mention of hernia,~~

~~Hemorrhage of rectum and anus,~~

~~Gastrointestinal hemorrhage,~~

~~Miscellaneous diseases of GI tract and peritoneum,~~

~~Cirrhoses of liver without mention of alcohol,~~

~~Other chronic liver disease and cirrhoses,~~

~~Other disorders of liver,~~

~~Gallbladder calculus with cholecystitis,~~

~~Gallbladder calculus without cholecystitis,~~

~~Nonacute cholecystitis,~~

~~Other diseases of gall bladder & bile duct,~~

~~Diseases of pancreas,~~

~~Chronic renal failure,~~

~~Acute pyelonephritis,~~

~~Other pyelonephritis or pyonephrosis,~~

~~Other diseases of kidney & ureter,~~

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~Urinary calculus,~~

~~Cystitis,~~

~~Urethral stricture,~~

~~Urinary tract infection,~~

~~Hematuria,~~

~~Other urinary disorders,~~

~~Redundant prepuce and phimosis,~~

~~Other diseases of male genital organs and prostate,~~

~~Inflammatory disease of ovary, Fallopian tube, pelvic cellular tissue, and peritoneum,~~

~~Inflammatory diseases of uterus, except cervix,~~

~~Inflammatory disease of cervix, vagina, and vulva,~~

~~Female genital prolapse,~~

~~Ovarian cyst,~~

~~Cyst/hemorrhage of vagina,~~

~~Excessive or frequent menstruation,~~

~~Other menstrual disorders or abnormal bleeding,~~

~~Other disorders of female genital organs,~~

~~Benign breast neoplasms/dysplasias,~~

~~Other disorders of breast,~~

~~Spontaneous abortion without complication,~~

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~Unspecified abortion without complication,~~

~~Other abortion,~~

~~Ectopic pregnancy,~~

~~Hemorrhage in early pregnancy,~~

~~Antepartum hemorrhage,~~

~~Hypertension complicating pregnancy, childbirth and puerperium,~~

~~Threatened premature labor,~~

~~Other threatened labor,~~

~~Early onset of delivery,~~

~~Other obstetrical diseases of antepartum & puerperium,~~

~~Normal delivery,~~

~~Malposition and malpresentation of fetus,~~

~~Disproportion related to delivery,~~

~~Uterine scar from previous pregnancy,~~

~~Trauma to perineum and vulva in delivery,~~

~~Forceps or vacuum extractor delivery without mention of indication,~~

~~Cesarian delivery without mention of indication,~~
~~Other delivery with complication,~~

~~Cellulitis and abscess of leg,~~

~~Other cellulitis and abscess,~~

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~Other infections of skin & subcutaneous tissue,~~

~~Other inflammations of skin and subcutaneous tissue,~~

~~Chronic ulcer of skin,~~

~~Other diseases of skin and subcutaneous tissue,~~

~~Arthopathies,~~

~~Intervertebral disorders,~~

~~Derangement of knee or other joint,~~

~~Other disorders of joint,~~

~~Acquired deformities of toe,~~

~~Other diseases of bone & cartilage,~~

~~Lumbago,~~

~~Other disorders of back,~~

~~Ganglion and cyst of synovium, tendon, bursa,~~

~~Other disorders of soft tissue,~~

~~Other diseases of muscle skeletal system,~~

~~Congenital anomalies,~~

~~Preterm infants,~~

~~Other perinatal jaundice,~~

~~Other conditions originating in perinatal period,~~

~~Syncope and prolapse,~~

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~Convulsions,~~

~~Pyrexia of unknown origin,~~

~~Headache,~~

~~Symptoms involving cardiovascular system,~~

~~Dyspnea and respiratory abnormalities,~~

~~Chest pain,~~

~~Other symptoms referable to nervous, respiratory, & circulatory systems,~~

~~Symptoms involving digestive system,~~

~~Symptoms involving urinary system,~~

~~Abdominal pain,~~

~~Other symptoms involving abdomen and pelvis,~~

~~Lack of expected normal physiological development,~~

~~Miscellaneous signs, symptoms, & ill defined conditions,~~

~~Fracture of face bones,~~

~~Other fracture of skull,~~

~~Fracture of neck and trunk,~~

~~Fracture of humerus,~~

~~Fracture of radius and ulna,~~

~~Other fracture of upper limb,~~

~~Fracture of femur,~~

~~Fracture of tibia and fibula,~~

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~Fracture of ankle,~~

~~Other fracture of lower limb,~~

~~Dislocations,~~

~~Sprains and strains of sacroiliac region,~~

~~Other sprains and strains of joints and adjacent muscles,~~

~~Concussion,~~

~~Other intracranial injury,~~

~~Other internal injury,~~

~~Open wound of head, neck, trunk,~~

~~Open wound of upper limb,~~

~~Open wound of lower limb,~~

~~Superficial injury,~~

~~Contusion with intact skin surface,~~

~~Other open wounds & superficial injuries,~~

~~Burn,~~

~~Complication of surgical & medical care,~~

~~Nondependent abuse of drugs,~~

~~Poisoning by drugs, medicinal, and biological substances,~~

~~Adverse effects of other substances,~~

~~3) Hospitals will be classified into three categories: rehabilitation, major teaching and other.~~

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~A) Rehabilitation hospitals are those participating hospitals whose total acute care patient days comprise less than 10% of their total patient days. Acute care patient days are defined as all days in hospital units with a length of stay of less than 30 days.~~

~~B) Major teaching hospitals are those hospitals which have four or more Graduate Medical Education Programs accredited by the American Medical Association, the American Dental Association, or the American Osteopathic Association, or have a scope of service rating as defined by the Illinois Health Finance Authority (IHFA) of 70 or more and have been approved by the IHFA on January 8, 1982, for inclusion in their peer groups 10, 11 and 12. (See IHFA Rule 7 Article 2). For out of state participating hospitals, hospitals with four or more Graduate Medical Education Programs accredited by the AMA, ADA, or AOA will be classified as major teaching hospitals.~~

~~C) All hospitals which are not classified as rehabilitation or major teaching shall be classified as "other" hospitals.~~

~~4) The Department will obtain a sample representative of the Department's mix of primary diagnoses and group them using the primary diagnosis groups in subsection (a)(2) for each hospital category. The sample used in these calculations will be the paid claims data base described in subsection (a)(1).~~

~~5) The statewide 80th percentile of lengths of stay for each diagnosis group will be calculated from the sample in subsection (a)(4).~~

~~6) The Department shall make the following data aggregation calculations and comparisons for each~~

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~major teaching hospital and each hospital classified as "other".~~

~~A) Obtain a sample representative of the Medical Assistance recipients' mix of primary diagnoses and group them using the primary diagnosis groups in subsection (a)(2).~~

~~B) Determine the hospital's total number of days in the sample.~~

~~C) Determine the hospital's total number of days in the sample in excess of the statewide 80th percentile for each diagnosis group.~~

~~7) The Department will reduce each hospital's total number of days in the sample in excess of the statewide 80th percentile as follows:~~

~~A) Calculate the mean length of stay for each diagnosis group for each hospital category from the sample in subsection (a)(4).~~

~~B) Calculate each hospital's mean length of stay for each diagnosis group from the sample in subsection (a)(6)(A).~~

~~C) For each diagnosis group, calculate a ratio by dividing the hospital's mean length of stay (subsection (a)(7)(B)) by the hospital group's mean length of stay (subsection (a)(7)(A))~~

~~D) If the ratio in step (subsection (a)(7)(C) is greater than 1, the hospital's mean length of stay exceeds the hospital group's mean length of stay and no offset will be given for that diagnosis group. If the ratio in step subsection (a)(7)(C) is less than 1, it will be subtracted from 1 and the result multiplied by the number of days in~~

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~excess of the 80th percentile for that diagnosis group (from subsection (a)(6)(C)) to determine the number of days the reduction will be offset.~~

~~8) To determine the final total of excess days the number of days in excess of the 80th percentile (subsection (a)(6)(C) will be lessened by the number of days, if any, credited as offsets (subsection (a)(7)(D)).~~

~~9) The Department will calculate for each hospital the ratio of excess days (subsection (a)(8)) to the total number of days (subsection (a)(6)(B)).~~

~~10) Each hospital's number of allowable covered days will be determined as follows:~~

~~A) The hospital's allowable number of days for services provided between October 1, 1981 and June 30, 1982, and payable in FY 1982 (calculated under Section 148.150 based on available data and any requested revisions by hospitals) will be increased proportionately so that the number of days is equal to the number provided during a full year.~~

~~B) The annualized expected number of days obtained in subsection (a)(10)(A) above shall be adjusted by the Department on the basis of historical experience to reflect estimated statewide changes in the number of persons eligible to receive Medical Assistance.~~

~~C) For major teaching and other participating hospitals, the product of the number of days obtained in subsection (a)(10)(B) and one minus the ratio obtained in subsection (a)(9) will be the total allowable covered days for each hospital for services provided on or after July 1, 1982.~~

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

~~D) For rehabilitation hospitals, the number of days obtained in subsection (a)(10)(B) above will be the total allowable covered days for services provided on or after July 1, 1982.~~

~~11) Payment by the Department for hospital services is payment in full and the hospital may not charge the recipient.~~

~~12) Days payable in fiscal year 1983, for purposes of Section 148.160, will be 80% of the total calculated in subsection (a)(10). This reflects an average historical delay of 73 days between date of service and date of payment.~~

~~b) Adjustments may be made by the Department to the allowable days by individual hospital to recognize significant changes in the number of admissions by diagnostic grouping, if the adjustments do not result in a net increase in the total allowable expenditures statewide. Requests should be submitted in writing within 6 months of the date the Department notifies the hospital of its number of allowable covered inpatient days. The Department will notify the hospital of the decision within 30 days.~~

a) In accordance with 89 Ill. Adm. Code 149.50(c)(8), state-owned hospitals in a county with a population greater than three million are excluded from the DRG PPS and are reimbursed in accordance with this section.

b) Base Year Costs

1) Each hospital's base year cost per diem shall be derived from audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospitals' fiscal years ending between 19 and 30 months prior to the fiscal year for which rates are being set (i.e., Calendar Year 1989 for Fiscal Year 1992 rates, Calendar Year 1990 for Fiscal Year 1993 rates, etc.) will be used to define base year costs.

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

2) For new hospitals for which a base year cost report is not on file, the Department will use a more recent filed cost report or, if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate based on a rate estimated as soon as a cost report becomes available. The recalculated rate will be effective for the entire fiscal year and the Department will retroactively adjust payments if reported costs are not consistent with the estimate on which the payments are based.

c) Restructuring Adjustment

Adjustments to base year costs will be made to reflect restructuring since filing the base year cost report. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost report available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost report to determine restructuring costs. If an audited cost report becomes available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Finance Section, Illinois Department of Public Aid, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Finance Section between the sixteenth and last day of the month, the effective date will be the first day of

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

the second month following the month the report is received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year costs.

d) Inflation Adjustment For Base Year Cost Report Inflator

Base year costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set (rate year) according to the index and methodology of Data Resources, Inc. (DRI), national market basket price proxies.

e) Review Procedure

The review procedure shall be in accordance with 89 Ill. Adm. Code 148.310.

f) Applicable adjustments for Disproportionate Share Hospitals and Uncompensated Care.

The criteria and methodology for making applicable adjustments to disproportionate share hospitals which are exempt from the DRG PPS as described in subsection (a) above, shall be in accordance with 89 Ill. Adm. Code 148.120. The criteria and methodology for making applicable adjustments for uncompensated care shall be in accordance with 89 Ill. Adm. Code 148.120(l) or 148.150, as applicable.

g) Outlier Adjustments

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with 89 Ill. Adm. Code 148.130.

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NOTICE OF ADOPTED AMENDMENTS

Section 148.170 ~~Limits on Length of Stay by Diagnosis~~ Payment Methodology for State-Owned Hospitals in a County with a Population of Over 3 Million (Cont'd)

h) Reductions to Total Payments

1) Copayments. Copayments are assessed under all medical programs administered by the Department except the General Assistance Program and shall be assessed in accordance with 89 Ill. Adm. Code 148.190.

2) Third Party Payments. The requirements of 89 Ill. Adm. Code 149.290(c)(2) shall apply.

i) Prepayment and Utilization Review

Prepayment and utilization review requirements shall be in accordance with 89 Ill. Adm. Code 148.240.

j) Cost Reporting Requirements

Cost reporting requirements shall be in accordance with 89 Ill. Adm. Code 148.210.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.180 Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting

a) For hospitals and/or distinct part units reimbursed on a per diem basis under 89 Ill. Adm. Code 148.160, 148.170 or 148.240 through 148.300, ~~Payment~~ payment for pre-operative days shall be limited to the day immediately preceding surgery unless the attending physician has documented the medical necessity of an additional day or days. The documentation must be kept in the patient's medical record and should consist of a written notation made by the physician which indicates that more than one pre-operative day is medically necessary.

b) Inpatient Hospital Services

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Section 148.180 Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting (Cont'd)

1) In accordance with 89 Ill. Adm. Code 148.140(a)(4), ~~Payment~~ payment for inpatient hospital services will not be made for procedures which have been identified as procedures which may be performed safely in an outpatient setting (i.e., without an admission to the hospital for an overnight stay) unless documentation in the patient's medical record indicates that:

A) The patient is in the hospital as an inpatient for a medically necessary condition unrelated to the surgical procedure;

B) The patient is in the hospital as an inpatient for an unrelated procedure to be performed on an inpatient basis simultaneously;

C) The practitioner has documented the medical necessity of performing the patient's surgery in an inpatient setting.

2) The list of procedures identified as restricted inpatient procedures which may be safely performed outside the inpatient setting and do not require an inpatient admission would be reevaluated annually.

3) Additions to and deletions from the list of designated restricted inpatient procedures will be made following notice to and consultations with the Department's professional advisory committees, State Medicaid Advisory Committee, ~~representatives~~ representatives selected by the hospitals, other third party payors, the Illinois Hospital Association, and other interested groups or individuals.

c) Ancillary services and routine tests (those services other than routine room and board and nursing which are required because of the patient's medical condition, including lab tests and x-rays) shall not be covered unless there is a patient specific written

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NOTICE OF ADOPTED AMENDMENTS

Section 148.180 Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting (Cont'd)

order for the test from the attending physician or responsible practitioner. (Standing orders are not sufficient.)

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.190 Copayments

a) Copayments will be assessed on inpatient hospital services in the following amounts:

1) Inpatient hospital services in hospitals with a ~~final~~ an alternate cost per diem rate (see Section ~~148.300~~ 148.270(a)) of $325 or more.....$3 per day.

2) Inpatient hospital services in hospitals with a ~~final~~ an alternate cost per diem rate of more than $275 but less than $325.....$2 per day.

3) Inpatient hospital services in hospitals with a ~~final~~ an alternate cost per diem rate of $275 or less.....No Copayment.

b) Copayments will be assessed under all medical programs administered by the Department except the General Assistance medical program. Copayments will not be assessed against individuals under the age of 18, pregnant women (including post-partum women who have given birth within the last six weeks), or group care recipients. Copayments will be deducted automatically by the Department upon payment for services provided.

c) No provider may deny care or services on account of an individual's inability to pay a copayment; this requirement, however, shall not extinguish the liability for payment of the copayment by the individual to whom the care or services were furnished.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

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NOTICE OF ADOPTED AMENDMENTS

Section 148.200 ~~Payment-Methodology~~-Alternate Reimbursement Systems

a) Section 148.210 discusses cost reporting requirements for all hospitals participating in the Medicaid Program.

b) Section 148.220 describes the payment methodology for hospital inpatient services to recipients for admissions occurring prior to September 1, 1991.

c) The payments described in 89 Ill. Adm. Code 148.80, 148.240 through 148.300 and Part 149 shall be effective for admissions on and after September 1, 1991.

d) In the interim, hospitals shall be reimbursed on a per diem basis for admissions on and after September 1, 1991.

1) The interim per diem reimbursement system will be replaced by the Medicaid Prospective Payment System no later than April 1, 1992 and appropriate adjustments will be made to adjust payments previously made under the interim per diem reimbursement system. The reimbursement methodologies described in 89 Ill. Adm. Code 148.240 through 148.300 and Part 149 shall be retroactive for admissions on or after September 1, 1991.

2) The payments described in 89 Ill. Adm. Code 148.120 shall be effective on or after July 1, 1991 with the exception of the payments described in 148.120(1) and 148.150 which shall be effective on or after August 1, 1991. In the interim, hospitals will continue to receive their disproportionate share reimbursement rate which was in effect on June 30, 1991. Once the Fiscal Year 1992 determination has been made and rates have been calculated for Fiscal Year 1992, appropriate retroactive adjustments will be made to the interim disproportionate share rates.

3) In the interim, hospitals shall be reimbursed as follows:

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NOTICE OF ADOPTED AMENDMENTS

Section 148.200 ~~Payment-Methodology~~-Alternate Reimbursement Systems (Cont'd)

A) Hospitals that, on August 31, 1991, have a contract with the Department under Section 3-4 of the Illinois Health Finance Reform Act shall elect to receive interim reimbursement under one of the reimbursement methodologies listed below:

i) The hospital's weighted average contracting rate as stated in the most recently negotiated contract.

ii) The payment methodology in effect August 31, 1991 in accordance with 89 Ill. Adm. Code 148.220.

B) Hospitals that, on August 31, 1991, do not have a contract with the Department under Section 3-4 of the Illinois Health Finance Reform Act shall continue to be reimbursed based upon the payment methodology in effect August 31, 1991, in accordance with 89 Ill. Adm. Code 148.220.

e) Sections ~~148.210~~-148.240 through-~~148.330~~ 148.300 describe the payment ~~methodology~~-methodologies for hospital inpatient services to recipients of Medical Assistance - Grant (MAG)~~,~~ and Medical Assistance - No Grant (MANG)~~,-Aid-to-the-Medically-Indigent-(AMI),-and-General-Assistance-(GA)~~ provided by a hospital not ~~covered~~-reimbursed under the ~~Illinois-Competitive-Access-and-Reimbursement-Equity-Program-(see-89-Ill.-Adm.-Code-149)~~ DRG Prospective Payment System (PPS) described in 89 Ill. Adm. Code Part 149 or the reimbursement methodologies described in 89 Ill. Adm. Code 148.160 and 148.170.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.210 ~~Non-Participating-Hospitals~~ Filing Cost Reports

~~a) Non-participating-out-of-state-hospitals-are-hospitals-from-out-of-state-that-provide-fewer-than-200-Illinois-Medical-Assistance-days-annually-and-that-do-not-file-an-Illinois-Medicaid-cost-report.~~

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NOTICE OF ADOPTED AMENDMENTS

Section 148.210 ~~Non-Participating-Hospitals~~ Filing Cost Reports (Cont'd)

~~b) Non-participating-out-of-state-hospitals-located-in-Metropolitan-Statistical-Areas-(MSA's)-designated-by-the-United-States-Department-of-Commerce-in-the-1980-census-shall-be-paid-by-computing-the-average-rate-paid-to-hospitals-located-in-the-Illinois-MSA-and-adjusting-this-amount-for-differing-wage-costs-and-differing-costs-associated-with-teaching-hospitals.--The-wage-cost-adjustment-shall-be-computed-using-the-wage-index-for-urban-areas-compiled-by-the-Federal-Bureau-of-Labor-Statistics.--The-teaching-cost-adjustment-shall-be-computed-based-on-the-relationship-as-defined-by-the-Illinois-Health-Finance-Authority-between-full-time-equivalent-interns-and-residents-employed-at-the-hospital-and-beds-at-the-hospital.--Hospitals-with-a-higher-ratio-of-interns-and-residents-to-beds-shall-receive-a-larger-percentage-add-on-to-their-computed-rate.~~

~~c) Non-participating-out-of-state-hospitals-not-located-in-MSA's-shall-be-paid-by-computing-the-average-rate-paid-to-hospitals-not-located-in-MSA's-in-Illinois,-and-adjusting-this-amount-for-differing-wage-costs-and-differing-costs-associated-with-teaching-hospitals.--The-wage-cost-adjustment-shall-be-computed-using-the-wage-index-for-rural-areas-compiled-by-the-Federal-Bureau-of-Labor-Statistics.--The-teaching-cost-adjustment-shall-be-computed-in-the-same-manner-as-specified-above-for-non-participating-hospitals-located-in-MSA's.~~

a) All hospitals in Illinois and those hospitals in contiguous states providing 200 or more inpatient days of care to Illinois program participants shall be required to file Medicaid cost reports within 90 days of the close of that provider's fiscal year.

b) The Department may grant a 30-day extension of the due date for good cause.

c) For new hospitals or distinct part units for which a base year Medicaid cost report is not on file, the hospital must submit a rate year budget and utilization estimate for the most recent hospital fiscal year. The Department will recalculate the rate estimate when a Medicaid cost report becomes available

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NOTICE OF ADOPTED AMENDMENTS

Section 148.210 ~~Non-Participating-Hospitals~~ Filing Cost Reports (Cont'd)

and will retroactively adjust payments, if reported costs are not consistent with the estimate on which the payments are based.

d) For a hospital that is electing to participate in the Illinois Medicaid Program and has not filed a Medicaid cost report before, the hospital must submit the most recently audited Medicare Cost Report at the time of enrollment.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.220 Pre ~~July 1, 1989 Services~~ September 1, 1991 Admissions

Reimbursement to ~~participating~~ hospitals for claims for ~~services provided~~ admissions occurring prior to ~~July 1, 1989~~ September 1, 1991, will be calculated and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered.

(Source: Amended at 16 Ill. Reg. 6255 effective March 27, 1992)

Section 148.230 ~~Post-June 30, 1989 Services~~ Admissions Occurring on or after September 1, 1991

Reimbursement to ~~participating~~ hospitals not reimbursed under the DRG PPS (see 89 Ill. Adm. Code Part 149) for inpatient ~~services provided during fiscal years~~ admissions occurring on or after ~~June 30, 1989,~~ September 1, 1991 shall be calculated in accordance with Sections 148.240 through ~~148.330~~ 148.300.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.240 Prepayment and Utilization Review

a) Prepayment Review

The Department may require hospitals to submit claims to the Department for prepayment review and approval

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NOTICE OF ADOPTED AMENDMENTS

Section 148.240 Prepayment and Utilization Review (Cont'd)

prior to rendering payment for services provided. Such prepayment review requirements will be focused on areas where the Department has substantial reason to suspect abuse (e.g., hospital billings deviate from the norm). The review may be conducted by the Department or its designated peer review agent. Prepayment review shall be used to determine the appropriateness and medical necessity of the inpatient stay. Payment shall not be made unless the medical necessity of the inpatient stay can be documented. The Department shall notify the hospital by letter or Department Informational Notice of the designated services which shall be subject to prepayment review. The prepayment review requirement shall commence thirty (30) days after the Department has given notice to the hospital of the designated services which shall be reviewed.

b) Denial of Payment as a Result of Admissions, Length of Stay, Transfers and Quality Review

1) If the Department determines that a hospital has misrepresented admissions, length of stay, discharges, or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:

A) Deny payment (in whole or in part) with respect to inpatient hospital services provided with respect to such an unnecessary admission, inappropriate length of stay or discharge, subsequent readmission or transfer of an individual.

B) Require the hospital to take action necessary to prevent or correct the inappropriate practice.

C) Perform prepayment review in accordance with 89 Ill. Adm. Code 148.240(a).

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NOTICE OF ADOPTED AMENDMENTS

Section 148.240 Prepayment and Utilization Review (Cont'd)

2) When payment with respect to the discharge of an individual patient is denied by the Department or its designee, under subsection (b)(1)(A), a reconsideration will be provided within 30 days upon the request of a practitioner or provider if such request is the result of the designee's own medical necessity or appropriateness of care denial determination and is received within 60 days of the Advisory Notice. The date of the Advisory Notice is counted as day one.

3) A determination under subsection (b)(1) above, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in:

A) withholding Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

B) termination of the hospital's Provider Agreement.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.250 Base-Year-Costs-Determination of Alternate Payment Rates to Certain Exempt Hospitals

~~a) Audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospitals' fiscal years ending between 19 and 30 months prior to the fiscal year for which rates are being set (i.e., calendar year 1981 for fiscal year 1984 rates, calendar year 1982 for fiscal year 1985 rates, etc.) will be used to define base year costs.~~

~~b) For new hospitals for which a base year cost report is not on file, the Department will use a more recent filed cost report or, if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate~~

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NOTICE OF ADOPTED AMENDMENTS

Section 148.250 Base-Year-Costs-Determination of Alternate Payment Rates to Certain Exempt Hospitals (Cont'd)

based-on-a-rate-estimate-as-soon-as-a-cost-report-becomes-available.--The-recalculated-rate-will-be-effective-for-the-entire-fiscal-year-and-the-Department-will-retroactively-adjust-payments-if-reported-costs-are-not-consistent-with-the-estimate-on-which-the-payments-are-based.

The exempt hospitals, defined in 89 Ill. Adm. Code 149.50(c)(1), (c)(2), (c)(4) and (c)(7), shall be reimbursed for inpatient hospital care provided to recipients by summing the following reimbursement calculations:

a) allowable operating cost per diem;

b) other costs (capital, direct medical education, and CRNA costs) reimbursed on a per diem basis; and

c) applicable disproportionate share and uncompensated care adjustments as described in 89 Ill. Adm. Code 148.120 or 148.150, as applicable, and outlier adjustments as described in 89 Ill. Adm. Code 148.130.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.260 Restructuring-Adjustment-Calculation and Definitions of Inpatient Per Diem Rates

Adjustments-to-base-year-costs-will-be-made-to-reflect-restructuring-since-filing-the-base-year-cost-report.--The-restructuring-must-have-been-mandated-to-meet-state,-federal-or-local-health-and-safety-standards.--The-allowable-Medicare/Medicaid-costs-(see-42-CFR-405,-Subpart-D,-1982)-must-be-incurred-as-a-result-of-mandated-restructuring-and-identified-from-the-most-recent-audited-cost-report-available-before-or-during-the-rate-year.--The-restructuring-costs-must-be-significant,-i.e.,-on-a-per-unit-basis,-they-must-constitute-one-percent-or-more-of-the-total-allowable-Medicare/Medicaid-unit-costs-for-the-same-time-period.--The-Department-will-use-the-most-recent-available-audited-cost-report-to-determine-restructuring-costs.--If-an-audited-cost-report-becomes-available-during-the-rate-year,-the-reimbursement-rate-will-be-recalculated-at-that-time-to-reflect-restructuring-cost-

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NOTICE OF ADOPTED AMENDMENTS

Section 148.260 Restructuring-Adjustment-Calculation and Definitions of Inpatient Per Diem Rates (Cont'd)

adjustments.--For-audited-reports-received-at-the-Finance-Section,-Illinois-Department-of-Public-Aid-between-the-first-and-fifteenth-of-the-month,-the-effective-date-of-the-recalculated-rate-will-be-the-first-day-of-the-following-month.--For-audited-reports-received-at-the-Finance-Section-between-the-sixteenth-and-last-day-of-the-month,-the-effective-date-will-be-the-first-day-of-the-second-month-following-the-month-the-report-is-received.--Allowable-restructuring-costs-are-adjusted-to-account-for-inflation-from-the-midpoint-of-the-restructuring-cost-reporting-year-to-the-midpoint-of-the-base-year-according-to-the-index-and-methodology-of-the-Data-Resources,-Inc.-(DRI)-national-market-basket-price-proxies,-hospital-inpatient-general-routine-operating-cost,-and-added-to-the-base-year-costs.

a) Calculation for the first rate year rate

1) Allowable operating cost per diem

A) The allowable operating cost per diem for a hospital, described in 89 Ill. Adm. Code 148.250(a), and for hospitals or hospital units, described in 89 Ill. Adm. Code 148.270, shall be calculated by taking the hospital's Medicaid inpatient operating costs (as reported on the hospital's latest audited Medicaid cost report on file with the Department, i.e., two hospital report years, 1988 and 1989, are used for FY'92 rates, 1989 and 1990 for FY'93, etc.) divided by the hospital's Medicaid inpatient days.

B) Operating cost base per diem rates for hospital inpatient care provided to Medicaid recipients beginning September 1, 1991, and ending August 31, 1992, shall be calculated by:

i) Calculating each individual hospital's cost per diem less capital and direct medical education costs for each of the two most recent years for which an

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Section 148.260 ~~Restructuring-Adjustment~~-Calculation and Definitions of Inpatient Per Diem Rates (Cont'd)

audited Medicaid cost report exists, as described in subsection (a)(1)(A) above.

ii) Each of the two cost per diems (i.e., one for 1988 and one for 1989) shall be trended forward to the midpoint of the current rate year using the national hospital market basket price proxies (DRI).

iii) These two trended operating cost per diems are then added together and divided by two to calculate the hospital's FY'92 final operating cost per diem.

2) Capital Related Costs. The capital related cost per diem for a hospital, described in 89 Ill. Adm. Code 148.250(a), and for hospitals or hospital units, described in 89 Ill. Adm. Code 148.270, shall be calculated by taking the hospital's total capital related costs (as reported on the hospital's latest audited Medicare cost report on file with the Department, i.e., two hospital report years, 1988 and 1989, are used for FY'92 rates, 1989 and 1990 for FY'93, etc.) divided by the hospital's total inpatient days, trended forward to the midpoint of the current rate year using the national hospital market basket price proxies (DRI).

A) These two trended capital related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.

B) The adjusted capital related cost per diem, as calculated in subsection (a)(2)(A) above, shall be rank ordered for all hospitals and capped at the 80th percentile.

C) Each hospital shall receive a per diem add-on for capital related costs which shall

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Section 148.260 ~~Restructuring-Adjustment~~-Calculation and Definitions of Inpatient Per Diem Rates (Cont'd)

be equal to the amount calculated in subsection (a)(2)(A) or subsection (a)(2)(B) above, whichever is less.

3) Direct Medical Education Costs. The direct medical education cost per diem for a hospital, described in 89 Ill. Adm. Code 148.250(a), and for hospitals or hospital units, described in 89 Ill. Adm. Code 148.270, shall be calculated by taking total direct medical education costs (as reported on the hospital's latest audited Medicare cost report on file with the Department, i.e., two hospital report years, 1988 and 1989, are used for FY'92 rates, 1989 and 1990 for FY'93, etc.) divided by the hospital's total inpatient days, trended forward to the midpoint of the current rate year using the national hospital market basket price proxies (DRI).

A) The two trended direct medical education cost per diems are then added together and divided by two to calculate the hospital's adjusted direct medical education cost per diem.

B) The adjusted direct medical education cost per diem, as calculated in subsection (a)(3)(A) above, shall be rank ordered for all hospitals reporting such costs and capped at the 80th percentile.

C) Each hospital shall receive a per diem add-on for direct medical education costs which shall be equal to the amount calculated in subsection (a)(3)(A) or subsection (a)(3)(B) above, whichever is less.

4) CRNA Costs

A) Only hospitals that qualify for these payments under the Medicare Program (Section 5261 of HCFA 14-3 Update, 3-1-91) shall be eligible for these payments.

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NOTICE OF ADOPTED AMENDMENTS

Section 148.260 ~~Restructuring-Adjustment-~~Calculation and Definitions of Inpatient Per Diem Rates (Cont'd)

B) The CRNA cost per diem shall be calculated by taking the hospital's total CRNA costs (as reported on the hospital's latest audited Medicare cost report on file with the Department, i.e., hospital report year 1989 is used for FY'92 rates, 1990 for FY'93, etc.) divided by the hospital's total inpatient days, trended forward to the midpoint of the current rate year using the national hospital market basket price proxies (DRI).

C) Each qualifying hospital, as described in subsection (a)(4)(A) above, shall receive a per diem add-on for CRNA costs which shall be equal to the amount calculated under subsection (a)(4)(B) above.

b) Calculation for the Second and Third Rate Years

For the rate years beginning on September 1, 1992, and on September 1, 1993, the final rate per diem shall be determined by taking the operating, capital, direct medical education and CRNA trended rate cost per diems calculated for the prior rate year and updating that rate by the national hospital market basket price proxies (DRI).

c) Calculation for Subsequent Rate Years

For the rate year beginning September 1, 1994, and every third rate year thereafter, the final rate per diem shall be calculated using the methodology set forth in subsection (a) using the most recently available audited Medicare/Medicaid cost reports.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

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Section 148.270 ~~Inflation-Adjustment-~~Determination of Alternate Cost Per Diem Rates For All Hospitals and Payment Rates for Certain Exempt Hospital Units

~~a) Base-Year-Cost-Report-Inflator~~

~~Base-year-costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set (rate year) according to the index and methodology of the Data Resources, Inc. national market basket price proxies, hospital inpatient general routine operating cost (DRI).~~

~~b) Group-65th-Percentile-Inflator~~

~~The Fiscal Year 1984 Group 65th percentile of DRI updated costs for hospital peer groups one through five (see Section 148.280) will be updated from the midpoint of the previous fiscal year to the midpoint of the current rate year according to the index and methodology of the Data Resources Inc., national market basket price proxies, hospital inpatient general routine operating cost (DRI). In this calculation, the full DRI index will be used.~~

a) For all hospitals, regardless of the hospital's reimbursement methodology, the Department shall first calculate the hospital's alternate cost per diem rate, as calculated under 89 Ill. Adm. Code 148.250 and 148.260, derived from the provider's two most recently audited inpatient Medicaid cost reports and the latest Medicare cost reports on file with the Department.

b) In the case of a distinct part unit, as described in 89 Ill. Adm. Code 149.50(d), the Department shall divide the hospital's Medicaid charges per diem (identified on paid claims submitted by the individual hospital during the most recently completed fiscal year) related to the distinct part unit by the hospital's total Medicaid charges per diem for all paid claims from the same time period, and multiply the result by the hospital's total Medicaid alternate payment rate. For rehabilitation care, the resulting figure shall be used as the hospital's distinct part unit's payment rate. For psychiatric care, the lower of the resulting figure or the hospital's Medicaid

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Section 148.270 ~~Inflation Adjustment~~ Determination of Alternate Cost Per Diem Rates For All Hospitals and Payment Rates for Certain Exempt Hospital Units (Cont'd)

alternate payment rate shall be used as the hospital's distinct part unit's payment rate. In the case of a new distinct part unit for which the Department has insufficient paid claims history data available, the Department shall utilize the average payment rate calculated under this subsection (b) for like distinct part units.

c) In the case of a new hospital (not previously owned or operated), a hospital that has significantly changed its case-mix profile (e.g. a general acute care hospital changing its case-mix to reflect a predominance of long term care patients), or an out-of-state non cost-reporting hospital, reimbursement for inpatient services shall be as follows:

1) For general acute-care hospitals, reimbursement for inpatient services shall be in the aggregate at the average net payment rate calculated under subsection (a) above for those hospitals reimbursed under 89 Ill. Adm. Code Part 149.

2) For psychiatric hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(1), reimbursement for inpatient psychiatric services shall be at the average rate calculated under 89 Ill. Adm. Code 148.250 through 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(1).

3) For rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), reimbursement for inpatient rehabilitation services shall be at the average rate calculated under 89 Ill. Adm. Code 148.250 through 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(2).

4) For long term care hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(4), reimbursement for inpatient services shall be at the average rate calculated under 89 Ill. Adm. Code 148.250 through 148.260 for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(4).

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Section 148.270 ~~Inflation Adjustment~~ Determination of Alternate Cost Per Diem Rates For All Hospitals and Payment Rates for Certain Exempt Hospital Units (Cont'd)

5) For children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3), reimbursement for inpatient services shall be at the average rate calculated under subsection (a) above for those hospitals defined in 89 Ill. Adm. Code 149.50(c)(3).

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.280 ~~Groupings~~ Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements

~~a) Hospitals will be grouped with their peers into five peer groupings:~~

~~1) Hospitals which provide only selected special services or programs are grouped separately from other hospitals. Special hospitals are subdivided into two groupings:~~

~~A) Rehabilitation hospitals (group 4)~~

~~B) Childrens hospitals (group 5)~~

~~2) All other hospitals are subdivided into three groupings:~~

~~A) Hospitals which have provided a large range of complex services, many of which have not been provided at other hospitals (group 1).~~

~~B) Hospitals which have provided a moderate range of complex services, some of which were not provided at any other hospital or services which have been provided at only a few other hospitals (group 2).~~

~~C) Hospitals which have provided a small range of complex services that have, for the most part, been provided at other facilities (group 3).~~

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Section 148.280 ~~Groupings~~-Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements (Cont'd)

~~b) Two variables were used to identify the hospital peer groups:~~

~~1) Primary diagnosis codes for inpatient admissions, as submitted by the hospitals on their inpatient claims.~~

~~2) Procedure codes from the same source.~~

~~3) Peer group methodology~~

~~A) Hospital peer groups are characterized by hospitals which share similar histories in terms of the complexity of services they have provided to Public Aid recipients.--Each hospital's Scope of Services Index (SOS) will be calculated from paid inpatient claims submitted for services provided during the two most recent fiscal years for which at least 95% of the claims have been processed.--Each hospital's SOS index will be updated on an annual basis.~~

~~B) All diagnosis and procedure codes (for surgical procedures) from these submitted claims are arrayed by hospital and unduplicated.--The number of hospitals that provided services related to each code (diagnosis and procedure) are tallied.--This sum is then divided by the total number of participating hospitals to obtain the percentage of hospitals which admitted patients for each diagnosis and procedure code.--This percentage is then substracted from one and multiplied by 100 to arrive at the complexity weight for each diagnosis and procedure code.--For instance, if a diagnosis/procedure were found in 10% of the hospitals paid claims, it would receive a complexity weight of 90 while a code turned up in 70% of the hospitals paid claims would receive a complexity weight of 30.--Once complexity weights are assigned to each code then the diagnosis and procedure code~~

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Section 148.280 ~~Groupings~~-Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements (Cont'd)

~~weights are summed for each hospital.--Each hospital's sum of diagnosis/procedure code weights are then divided by the total of all the diagnosis/procedure code weights and multiplied by 100.--Each hospital has four weights:--one for diagnosis codes and one for procedure codes for each of the two years considered.--These four weighted measures are then added together and divided by four and then the result is multiplied by 1000 to develop a combined weight index to measure the complexity of care each hospital has provided to Public Aid recipients.~~

~~c) The discussed methodology results in the following groupings.~~

~~Group Number~~	~~Diagnostic Scope of Service Range~~
~~--1~~	~~Greater than the mean SOS score plus two (2) standard deviations~~
~~--2~~	~~Greater than the mean SOS score plus one (1) standard deviation but less than the mean SOS plus 2 standard deviations~~
~~--3~~	~~Less than the mean SOS score plus one (1) standard deviation~~
~~--4~~	~~N/A~~
~~--5~~	~~N/A~~

~~d) Any new or out of state participating hospitals will be placed in the most appropriate grouping based on data collected by the Department.~~

a) Children's Hospitals

1) For purposes of reimbursement, all children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3), are grouped into one peer group.

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Section 148.280 ~~Groupings~~-Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements (Cont'd)

2) Each hospital's costs shall be derived from audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospitals' fiscal years ending between 19 and 30 months prior to the fiscal year for which the rates are being set (i.e., Calendar Year 1989 for Fiscal Year 1992, etc.).

3) These base year costs shall be updated, trended forward, from the midpoint of each hospital's base year (i.e., 1989) to the midpoint of the rate year (i.e., 1992) for which rates are being set according to the methodology of the national total hospital market basket price proxies, (DRI).

4) The children's hospitals' FY'92 trended rates shall be used as the basis for calculating the group's median trended rate. Each individual hospital's trended rate is then compared to the group's median trended rate. Hospitals whose individual trended rates are higher than the median rates shall receive as a final inpatient payment rate their trended rate minus half the difference between their trended rate and the group's median trended rate. Hospitals whose trended rates are lower than the group's median trended rate shall receive as its final inpatient payment rate their individual trended rate plus half the difference between their trended rate and the group's median trended rate.

b) Hospitals Reimbursed Under Special Arrangements

During the transition period of the DRG PPS implementation, hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

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NOTICE OF ADOPTED AMENDMENTS

Section 148.290 ~~Rate Calculation~~-Adjustments and Reductions to Total Payments

~~Final rate calculation~~

~~a) For Groups 1 through 5 the 65th percentile of the DRI updated costs for individual hospitals within a group will be increased by the DRI Index from the midpoint of the previous year to the midpoint of the rate year. The 65th percentile is derived from the FY 84 trended rates which have been updated each year for inflation.~~

~~b) The Final Rate for a hospital with current rate year DRI updated costs greater than its current rate year group 65th percentile will be the group 65th percentile. The Final Rate for a hospital with DRI updated costs less than or equal to its current rate year group 65th percentile will be either:~~

~~1) (the DRI index updated from the midpoint of the previous year to the midpoint of the rate year plus that hospital's marginal percentage change in per diem trended costs from the previous to the current rate year) divided by two, multiplied by the previous year's trended cost; or,~~

~~2) the current rate year group 65th percentile, whichever is less. This final adjustment will decrease the rate of increase for hospitals with per diem costs increasing faster than the inflation rate and increase the rate of increase for hospitals with per diem costs increasing slower than the inflation rate.~~

a) Applicable Adjustments for Disproportionate Share and Uncompensated Care

The criteria and methodology for making applicable disproportionate share and uncompensated care adjustments to hospitals which are exempt from the DRG PPS (see 89 Ill. Adm. Code Part 149) shall be in accordance with 89 Ill. Adm. Code Sections 148.120 or, if applicable, 148.150.

b) Outlier Adjustments

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving

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NOTICE OF ADOPTED AMENDMENTS

Section 148.290 ~~Rate-Calculation~~-Adjustments and Reductions to Total Payments (Cont'd)

exceptionally high costs for certain individuals shall be made in accordance with 89 Ill. Adm. Code 148.130 for hospitals that are exempt from the DRG PPS (see 89 Ill. Adm. Code Part 149).

c) Reductions to Total Payments

1) Copayments. Copayments are assessed under all medical programs administered by the Department except the General Assistance medical program and shall be assessed in accordance with 89 Ill. Adm. Code 148.190.

2) Third Party Payments. Hospitals shall determine that services are not covered, in whole or in part, under any program or under any other private group indemnification or insurance program, health maintenance organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.300 Payment

The Department will pay the full final rates calculated in Sections 148.250 - 148.290 for hospitals described in 89 Ill. Adm. Code 148.200(e).

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.310 Review Procedure

a) Inpatient Rate Reviews

1) Hospitals shall be notified of their inpatient rate for the rate year and shall have an opportunity to request a review of the rate for errors in calculation. Such a request must be

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NOTICE OF ADOPTED AMENDMENTS

Section 148.310 Review Procedure (Cont'd)

received in writing by the Department within 30 days of the date of the Department's notice to the hospital of their rates. The Department shall notify the hospital of the results of the review within 30 days of receipt of the hospital's request for review.

2) Hospitals reimbursed in accordance with 89 Ill. Adm. Code 148.240 through 148.300 may request that an adjustment be made to their base year costs to reflect significant changes in costs which have occurred since the hospital's filing of the base year cost report. The allowable Medicare/Medicaid costs must be identified from the most recent audited cost report available. These costs must be significant, i.e., on a per unit basis, they must constitute one percent or more of the total allowable Medicaid/Medicare unit costs for the same time period. Appeals for base year cost adjustments must be received, in writing, by the Department within 30 days of the date of the Department's notice to the hospital of their rates. Such request shall include a clear explanation of the cost change and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days of receipt of the hospital's request for review.

3) Allowable costs are adjusted to account for inflation from the midpoint of the cost reporting year to the midpoint of the base year according to the index and methodology of the total hospital national market basket price proxies, (DRI), and added to the base year costs.

b) Disproportionate Share Determination Reviews

1) Hospitals shall be notified of their qualification for disproportionate share payment adjustments and shall have an opportunity to request a review of the disproportionate share add-on for errors in calculation. Such a request must be received in writing by the Department within 30 days of the date of the Department's notice to the hospital of its disproportionate share qualification and add-on calculations.

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Section 148.310 Review Procedure (Cont'd)

Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days of receipt of the hospital's request for review.

2) Disproportionate share determination reviews shall be limited to the following:

A) Disproportionate Share Determination Criteria. The criteria for disproportionate share determination shall be in accordance with Section 1923 of the Social Security Act, Public Act 86-268 and 89 Ill. Adm. Code 148.120. Review shall be limited to verification that the Department utilized criteria in accordance with federal and State regulations.

B) Medicaid Inpatient Utilization Rates. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act, Public Act 86-268 and 89 Ill. Adm. Code 148.120(a)(1). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

C) Low Income Utilization Rates. Low Income utilization rates shall be calculated in accordance with Section 1923 of the Social Security Act and 89 Ill. Adm. Code 148.120(a)(2) and (d). Review shall be limited to verification that low income utilization rates were calculated in accordance with federal and State regulations.

D) Federally Designated Health Manpower Shortage Areas (HMSA's). Illinois hospitals located in federally designated HMSA's shall be identified in accordance with 42 CFR 5, 1989, Public Act 86-268 and 89 Ill. Adm. Code 148.120(a)(3) based upon the methodologies utilized by, and the most

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Section 148.310 Review Procedure (Cont'd)

current information available to, the Department of Health and Human Services as of June 30th of the fiscal year prior to the disproportionate share determination. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HMSA's only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HMSA as of June 30th of the fiscal year prior to the disproportionate share determination.

E) Excess Beds. Excess bed information shall be determined in accordance with Public Act 86-268 (89 Ill. Admin. Code, Section 148.120(a)(3) and 77 Ill. Admin. Code, Section 1100) based upon the methodologies utilized by, and the most current information available to, the Illinois Health Facilities Planning Board as of June 30th of the fiscal year prior to the disproportionate share determination. Reviews shall be limited to requests accompanied by documentation from the Illinois Health Facilities Planning Board substantiating that the information supplied to and utilized by the Department was incorrect.

F) Occupancy Ratios. Occupancy rates shall be determined in accordance with Public Act 86-268 and 89 Ill. Adm. Code 148.120(m)(6) and (7) based upon the methodologies utilized by, and the most current information available to, the Illinois Department of Public Health as of June 30th of the fiscal year prior to the disproportionate share determination. Reviews shall be limited to requests accompanied by documentation from the Illinois Department of Public Health substantiating that the information supplied to and utilized by the Department was incorrect.

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Section 148.310 Review Procedure (Cont'd)

G) Medicare Inpatient Utilization Percentages. Medicare inpatient utilization percentages shall be calculated in accordance with Public Act 86-268 and 89 Ill. Adm. Code 148.120(m)(3) through (5) based upon the hospital's cost report for the hospital's base fiscal year (i.e., Calendar Year 1986 for Fiscal Year 1989 payments, Calendar Year 1987 for Fiscal Year 1990, etc.). Reviews shall be limited to requests accompanied by documentation from the Medicare intermediary substantiating that the information supplied to and utilized by the Department was incorrect.

c) Outlier Adjustment Reviews. The Department shall make outlier adjustments to payment amounts in accordance with 89 Ill. Adm. Code 149.105 or 148.130, whichever is applicable. Hospitals shall be notified of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment and shall have an opportunity to request a review of such specific information for errors in calculation only. Such a request must be received in writing by the Department within 30 days of the date of the Department's notice to the hospital of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days of receipt of the hospital's request for review.

d) Cost Report Reviews. Cost reports are required from: 1) all enrolled hospitals within the State of Illinois; and 2) all out-of-state hospitals anticipating or providing 200 inpatient days of service per hospital fiscal year, to persons covered by the Illinois Medical Assistance Program. The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted annually within 90 days of the close of the hospital's fiscal year. A one-time 30-day extension may be requested. Such a request for an extension shall be in writing and shall be received by

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Section 148.310 Review Procedure (Cont'd)

the Department's Office of Health Finance prior to the end of the 90-day filing period. The Office of Health Finance shall audit the information shown on the Hospital Statement of Reimbursable Cost and Support Schedules. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report which may contain adjustments and revisions which may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing by the Department within 45 days of the date of the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis which support the request for review. No additional data shall be accepted after the 45 day period. The Department shall notify the hospital of the results of the review within 30 days of receipt of the hospital's request for review.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.320 Alternatives

a) The provisions of Sections ~~148.200~~ 148.240 through 148.310 of this rule shall be in effect during the fiscal year for so long as the Director of the Department finds that:

1) The total number of hospitals agreeing to be reimbursed pursuant to the provisions of this rule is sufficient to assure that medical assistance recipients have reasonable access to hospital services. In making this determination, factors considered by the Department include but are not limited to service availability and the number of recipients within a geographic area, recipient travel time to obtain services, and availability of a range of services within the geographic area.

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Section 148.320 Alternatives (Cont'd)

2) The provisions are approved by the Department of Health and Human Services in the State Title XIX Plan.

3) The Department has not been enjoined, restrained of otherwise delayed or prohibited by Court order or actions of entities other than the Department from enforcing the provisions.

b) If any of the conditions specified above fail to occur, alternative service coverage and reimbursement limitations shall be implemented to assure that payments for hospital services during a fiscal year will be approximately the same as would have been made under this rule.

(Source: Amended at 16 Ill. Reg. 6255, effective March 27, 1992)

Section 148.400 Special Hospital Reporting Requirements

Corrective Action Plans. Hospitals are responsible for assuring that services provided to Medicaid program participants meet or exceed the appropriate standards for care. Any provider that is under any corrective action plan(s), while enrolled with the Department, by any licensing, certification and/or accreditation authority, including, but not limited to, the Illinois Department of Public Health, the Federal Department of Health and Human Services, a peer review organization, and/or the Joint Commission for Accreditation of Health Care Organization, must report the request for such corrective action plans to the Department. Information submitted will remain confidential.

(Source: Added at 16 Ill. Reg. 6255 effective March 27, 1992)

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

1) The Heading of the Part: MEDICAL PAYMENT

2) Code Citation: 89 Ill. Adm. Code 140

3)

Section Numbers:	Adopted Action:
140.94	New Section
140.95	New Section
140.530	Amendment
140.538	Amendment
140.552	Amendment
140.562	Amendment
140.569	Amendment
140.583	Amendment
140.835	Repealed

4) Statutory Authority:

89 Ill. Adm. Code 140.94 and 140.95

Sections 5-4.20 through 5-4.39 and Sections 14-1 through 14-10 of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, Ch. 23, Pars. 5-4.20 through 5-4.39 and Sections 14-1 through 14-10, as added by Public Act 87-13)

89 Ill. Adm. Code 140.530 thru 140.835

Sections 5-5.1 et seq. and 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, Ch. 23, Pars. 5-5.1 et seq. and 12-13)

5) Effective Date of Adopted Amendments: March 20, 1992

6) Does this rulemaking contain an automatic repeal date?
___Yes _X_No

7) Do these Adopted Amendments contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: March 20, 1992

9) Notice of Proposal Published in Illinois Register:

November 8, 1991 (15 Ill. Reg. 15933)

10) Has JCAR issued a Statement of Objections to these Adopted Amendments? No

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11) Differences between proposal and final version:

Section 140.94

Subsection (e)(2) - add the following language at the end: "If, as a result of the reconciliation, the Department determines that the amount of the reconsidered fee was incorrect, this notification shall include an adjustment to the amount of the provider participation fee which is next due. The facility shall be obligated to pay the amount shown on the reconciliation notification if that amount differs from the amount in the notification described in subsection (d)."

Subsection (h) - changed "for" to "in".

Subsection (h)(1)(E)(iii) - add "or a statement of interest waiver" after "interest".

Subsection (h)(1)(E)(iv) - add "any agreement selling the entity will include provisions that the new owners" after "of the liability and".

Subsection (h)(3)(A) - changed "seven (7)" to "ten (10)"; add "Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request." before the sentence "All telefax...".

Subsection (l)(1) - add "within 9 months from the end of the State fiscal year in which the fee described in subsection (b) is due" after "facilities".

Subsection (l)(2) - add "or gross receipts as determined and utilized by the Department in the calculation of fees due under subsection (b)" after "services" in the first sentence; delete "during the period"; add "or actual gross receipts during the period to which the provider participation fee relates" after "actual utilization"; delete "for that period"; replace "assessment year utilization base" with "utilization and actual gross receipts for the period to which the provider participation fee relates".

Subsection (l)(2)(A) - add "of the date of notification from the Department that monies are owed to the Department," after "60 days".

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Subsection (l)(2)(B) - add "of the date of notification from the Department that monies are due the facility," after "60 days".

Subsection (n) - insert new subsections (1), (2) and (3) and renumber existing subsections (1) - (4).

Section 140.95

Subsection (b)(3) - add "as calculated in accordance with 89 Ill. Adm. Code Section 148.120(k)" at the end of this subsection.

Subsection (e)(2) - add "If as a result of the reconciliation, the Department determines that the amount of the reconsidered fee was incorrect, the notification shall include an adjustment to the amount of the provider participation fee which is next due. The facility shall be obligated to pay the amount shown on the reconciliation notification if that amount differs from the amount in the notification described in subsection (d)." at the end of the subsection.

Subsection (h) - changed "for" to "in".

Subsection (h)(1)(E)(iii) - add "or a statement of interest waiver" after "interest".

Subsection (h)(1)(E)(iv) - add "any agreement selling the entity will include provisions that the new owners" after "of the liability and".

Subsection (h)(3)(A) - changed "seven (7)" to "ten (10)"; add "Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request." before the sentence "All telefax...".

Subsection (l)(2)(A) - add "of the date of notification from the Department that monies are owed to the Department," after "60 days".

Subsection (l)(2)(B) - add "of the date of notification from the Department that monies are due" after "60 days"; add "," after "to the hospital".

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NOTICE OF ADOPTED AMENDMENTS

Section 140.569

Subsection (a)(3) has been revised to read "In order for a person to be assessed for exceptional care placement the hospital must be entitled to receive Medicaid reimbursement as the primary source of payment for this person."

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will these Adopted Amendments replace Emergency Amendments currently in effect? Yes

14) Are there any Amendments pending on this Part? Yes

Section Numbers	Proposed Action	Illinois Register Citation
140.13	Amendment	March 27, 1992 (16 Ill. Reg. 4708)
140.14	Amendment	March 27, 1992 (16 Ill. Reg. 4708)
140.16	Amendment	March 27, 1992 (16 Ill. Reg. 4708)
140.19	Amendment	March 27, 1992 (16 Ill. Reg. 4708)
140.27	Amendment	January 3, 1992 (16 Ill. Reg. 65)
140.31	New Section	March 27, 1992 (16 Ill. Reg. 4708)
140.32	New Section	March 27, 1992 (16 Ill. Reg. 4708)
140.33	New Section	March 27, 1992 (16 Ill. Reg. 4708)
140.512	Amendment	September 13, 1991 (15 Ill. Reg. 13274)
140.513	Amendment	September 13, 1991 (15 Ill. Reg. 13274)

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Section Numbers	Proposed Action	Illinois Register Citation
140.526	Repealed	January 10, 1992 (16 Ill. Reg. 472)
140.527	Repealed	January 10, 1992 (16 Ill. Reg. 472)
140.528	Repealed	January 10, 1992 (16 Ill. Reg. 472)
140.529	Repealed	January 10, 1992 (16 Ill. Reg. 472)
140.539	Amendment	January 10, 1992 (16 Ill. Reg. 472)
140.543	Amendment	February 28, 1992 (16 Ill. Reg. 3045)
140.560	Amendment	April 19, 1991 (15 Ill. Reg. 5585)
140.565	Amendment	January 24, 1992 (16 Ill. Reg. 1492)
140.566	Amendment	March 27, 1992 (16 Ill. Reg. 4708)
140.579	Amendment	March 6, 1992 (16 Ill. Reg. 3409)
140.600	New Section	January 10, 1992 (16 Ill. Reg. 472)
140.602	New Section	January 10, 1992 (16 Ill. Reg. 472)
140.604	New Section	January 10, 1992 (16 Ill. Reg. 472)
140.608	New Section	January 10, 1992 (16 Ill. Reg. 472)
140.610	New Section	January 10, 1992 (16 Ill. Reg. 472)
140.612	New Section	January 10, 1992 (16 Ill. Reg. 472)

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Section Numbers	Proposed Action	Illinois Register Citation
140.614	New Section	January 10, 1992 (16 Ill. Reg. 472)

15) Summary and Purpose of Adopted Amendments:

89 Ill. Adm. Code 140.94 "Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund"

Under this rulemaking intermediate care facilities for the developmentally disabled and skilled and intermediate nursing facilities, including county nursing homes, are required to pay a provider participation fee to the Department of Public Aid equal to 15% of the provider's Medicaid payments. They are used, in conjunction with other State funds, as the State's match in order to receive Federal Financial Participation for medical services.

89 Ill. Adm. Code 140.95 "Hospital Services Trust Fund"

Under this rulemaking, hospitals are required to pay certain provider participation fees to the Department. One fee equals 50% of the difference between the hospital's anticipated Medicaid payments for the current fiscal year and what the hospital's payments would have been in the current fiscal year, based on Fiscal Year 1991 payments less 5%. A second fee equals 5% of the hospitals payments from the Department last fiscal year. A third fee is imposed only on hospitals receiving critical care access payments and equals 50% of those payments. These fees are used, in conjunction with other State funds, as the State's match in order to receive Federal Financial Participation for medical services.

The rule sets forth guidelines for the amount of the fees, the payment of the fees, delayed payment of fees, reconsideration and reconciliation on the amount of the fee, penalties for late payment of the fees, disbursement of the fees from the fund to the providers and annual audits. This structure of fees and disbursements is conditioned upon the availability of federal funds under Title XIX of the Social Security Act to match the fees collected and disbursed. If federal matching funds become unavailable, these rules shall no longer apply.

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89 Ill. Adm. Code 140.530 "Basis of Payment for Long Term Care Services"

This rulemaking deletes the requirement that Department rates to nursing facilities may not exceed a facility's charges to private pay residents. This brings Department rules in this regard into accord with federal regulations. This change has no fiscal impact on the Department's expenditures.

89 Ill. Adm. Code 140.538 "Special Costs"

This rulemaking provides that the assessment fee does not become an allowable cost for double reimbursement in future cost reports. This change has no fiscal impact on the Department's expenditures.

89 Ill. Adm. Code 140.552 "Nursing and Program Costs"

This rulemaking removes the Illinois Experience factor. This change is estimated to increase the Department's aggregate expenditures for nursing facilities by $17.3 million in Fiscal Year 1992.

89 Ill. Adm. Code 140.562 "Nursing Costs"

This rulemaking removes the 7.1% nursing wage adjustment factor. The costs associated with elimination of this 7.1% are being distributed to certain categories of the IOC survey. A proposed/emergency rulemaking addressing those distributions is being contemperaneously filed with this rulemaking. Accordingly, this change will not have a fiscal impact on the Department's annual aggregate expenditures for Fiscal Year 1992.

89 Ill. Adm. Code 140.569 "Clients With Exceptional Care Needs"

This rulemaking will allow facilities with Medicaid eligible residents, that have been discharged from the hospital or are transitioning from Medicare to Medicaid while in the nursing facility, to be assessed for exceptional care reimbursement. The proposed rule is also lowering the cost requirement from 50% to 25% more than the proposed admitting facility's per diem rate. This change is estimated to increase the Department's aggregate expenditures for nursing facilities by $3 million in Fiscal Year 1992.

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89 Ill. Adm. Code 140.583 "Campus Facilities"

This rulemaking revises the methodology used to determine rates for Campus Facilities to encompass the assessment fee. This change is estimated to increase the Department's aggregate expenditures for nursing facilities by $100,000 in Fiscal Year 1992.

89 Ill. Adm. Code 140.835 "Determination of Cap on Payments for Long Term Care"

This section is obsoleted and accordingly repealed because the Department is deleting the requirement that Department rates for nursing facilities may not exceed a facility's charges to private pay residents. This change has no fiscal impact on the Department's expenditures.

16) Information and questions regarding these Adopted Amendments shall be directed to:

Name: JoAnne Jones
Bureau of Rules and Regulations

Address: Illinois Department of Public Aid
Jesse B. Harris Building II
100 South Grand Avenue East, 3rd Floor
Springfield, Illinois 62762

Telephone: (217)524-3215

The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 140
MEDICAL PAYMENT

SUBPART A: GENERAL PROVISIONS

Section
140.1 Incorporation By Reference
140.2 Medical Assistance Programs
140.3 Covered Services Under The Medical Assistance Programs for AFDC, AFDC-MANG, AABD, AABD-MANG, RRP, Individuals Under Age 18 Not Eligible for AFDC, Pregnant Women Who Would Be Eligible if the Child Were Born and Pregnant Women and Children Under Age Eight Who Do Not Qualify As Mandatory Categorically Needy
140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
140.5 Covered Medical Services Under GA
140.6 Medical Services Not Covered
140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight
140.8 Medical Assistance For Qualified Severely Impaired Individuals
140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
140.10 Medical Assistance Provided to Incarcerated Persons

SUBPART B: MEDICAL PROVIDER PARTICIPATION/DRUG MANUAL

Section
140.11 Enrollment Conditions for Medical Providers
140.12 Participation Requirements for Medical Providers
140.13 Definitions
140.14 Denial of Application to Participate in the Medical Assistance Program
140.15 Recovery of Money
140.16 Termination of a Vendor's Eligibility to Participate in the Medical Assistance Program
140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program

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SUBPART E: GROUP CARE

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SUBPART F: MEDICAID PARTNERSHIP PROGRAM

SUBBPART G: REIMBURSEMENT FOR NURSING COSTS FOR GERIATRIC FACILITIES

SUBPART H: ILLINOIS COMPETITIVE ACCESS AND REIMBURSEMENT EQUITY (ICARE) PROGRAM

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AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1989, ch. 111 1/2, par. 6503-1 et seq.) and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13)

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at

7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; recodified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg.10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138,

effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986;emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg.15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg. 7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.Table H and 140.Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147.Table A and 147.Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12

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Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7025, effective April 24, 1989; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5,

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1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; Section 140.569 withdrawn at 15 Ill. Reg. 1174; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 15 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE.

SUBPART C: ~~HOSPITAL SERVICES~~ PROVIDER PARTICIPATION FEES

Section 140.94 ~~Hospital Services (Reedified)~~ Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund

a) Purpose and Contents

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 140.94 ~~Hospital Services (Reedified)~~ Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund (Cont'd)

1) The Funds were created in the State Treasury upon enactment of Public Act 87-13. Interest earned by the Funds shall be credited to the appropriate Fund. The Funds shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Funds are created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 87-13.

3) The Funds shall consist of:

A) All monies collected or received by the Department under subsections (b) below;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Funds;

C) Any interest or penalty levied in conjunction with the administration of the Funds; and

D) All other monies received for the Funds from any other source, including interest earned thereon.

b) Provider Participation Fees

Beginning on July 1, 1991, a fee is imposed upon each facility in an amount equal to 15% of the facility's gross receipts for services provided for the previous State fiscal year as determined and reported by the Department.

c) Payment of Fees Due

1) The fees described in subsection (b) above shall be due and payable on a calendar quarterly basis.

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 140.94 ~~Hospital Services (Reedified)~~ Medicaid Developmentally Disabled Provider Participation Fee Trust Fund/Medicaid Long Term Care Provider Participation Fee Trust Fund (Cont'd)

2) The fees shall be payable to and collected by the Department in quarterly amounts due and received by the Department at the address specified on the Provider Participation Fee Notice described in subsection (d) on the first business day of the first calendar quarter following the quarter for which the fee is being paid, with the exception of the initial payment which shall be due within thirty (30) days of the date of the Department's notification of the fee due. The subsequent quarterly amounts shall be due on January 1, April 1, July 1 and October 1 of each year. All monies collected under subsections (b) and (c) shall be deposited into the appropriate Fund. For facilities which sign an amendment to their provider agreement stating they will be terminating operation at a specific point in time, the Department will make an adjustment in the fee based on a quarterly average public assistance occupancy level.

3) All payments received by the Department shall be credited first to any interest or penalty, and then to the fee due.

4) County nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their fee obligation by the county government certifying to the Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the fee. County governments wishing to provide such certification must:

A) Sign a certification form certifying that the funds represent expenditures eligible for federal financial participation under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and that these funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds;

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B) Submit the certification document to the Department once a year along with a copy of that portion of the county budget showing the funds appropriated for the operation of the county nursing home. These documents must be submitted within 30 days of the final approval of the county budget. However, for state fiscal year 1992, the county budgets covering the periods December 1, 1990 through November 30, 1991 and December 1, 1991 through November 30, 1992 must be submitted;

C) Submit the monthly claim form in the amount of the rate established by the Department minus any third party liability amount. This amount will be reduced by one twelfth of the annual assessment amount prior to payment as a certification statement was provided in lieu of an actual assessment payment; and

D) Make records available upon request to the Department and/or the United States Department of Health and Human Services pertaining to the certification of county funds.

d) Notification

The Department shall notify each facility of the results of its calculations under subsections (b) and (c) above. The notification shall be in writing and shall be submitted to the facility at least 30 days prior to the date on which the provider participation fee is due. Such calculations shall be subject to quarterly reconciliations as described in subsection (e) below and the annual audit/reconciliation described in subsection (l) below.

e) Procedure for Reconsideration and Quarterly Reconciliation

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1) Reconsiderations. Upon notification of the results of the Department's calculations under subsections (b) and (c) above, each facility shall have the right to reconsideration of the calculation of its provider participation fee for that quarter. Only requests for reconsideration of the assessment calculation shall be considered during the quarterly reconciliation period. All appeals based on utilization/spending estimates shall be addressed during the annual audit/reconciliation described in subsection (k) below.

A) Requests for reconsideration must be received in writing within 30 calendar days of the date of the Department's notification of the fee due. The request shall be accompanied by written materials setting forth the grounds for reconsideration.

B) A facility shall be required to pay its provider participation fee amount for the time period in question. In the event that a request for reconsideration results in the need for an adjustment to the fee due for the subject quarter, such adjustment shall be made during the quarterly reconciliation for the subject quarter.

2) Quarterly Reconciliation. A quarterly reconciliation shall be performed by the Department to make adjustments to the fees calculated by the Department under subsections (b) and (c) above. During the quarterly reconciliation, the Department shall consider all requests for reconsideration which are received in compliance with subsection (e)(1) above. The Department shall notify each facility of the results of the quarterly reconciliation. The notification shall be in writing and shall be submitted to the facility at least ten (10) working days prior to the date on which the

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subsequent provider participation fee is due. If as a result of the reconciliation, the Department determines that the amount of the reconsidered fee was incorrect, this notification shall include an adjustment to the amount of the provider participation fee which is next due. The facility shall be obligated to pay the amount shown on the reconciliation notification if that amount differs from the amount in the notification described in subsection (d).

f) Penalties

1) Any facility that fails to pay the fee when due or pays less than the full amount due as described in subsections (b) and (c) above, shall be assessed a penalty of ten (10%) percent of the delinquency or deficiency for each month, or fraction thereof, computed on the full amount of the delinquency or deficiency, which includes any penalty accrued and not paid, from the time the fee was due.

2) Within five days from the due date, the Department will begin immediate recoupment actions against the delinquent facility by withholding the amount due from future payments. No payments will be made to the facility until the entire provider fee, including any penalties, is satisfied. Recoupment proceedings against the same facility two times in a fiscal year shall be cause for termination from the Program.

3) If the facility is no longer doing business with the Department or the Department cannot recover the full amount due, including penalties and interest, within three months of the fee due date, the Department may begin legal action to recover the monies owed plus court costs.

4) The Director of the Department of Public Aid is authorized to establish delayed payment schedules

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for individual facilities that are unable to make timely payments under this Section due to financial difficulties. The delayed payment provisions are described in subsections (g) and (h) below.

g) Delayed Payment - Groups of Facilities.

The Director may establish delayed payment of fees and/or waive the payment of interest and penalties for groups of facilities when:

1) the State delays payments to facilities due to problems related to state cash flow, or

2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the fee.

h) Delayed Payment - Individual Facilities

In addition to the provisions of subsection (g) above, the Director may waive or delay fees for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter in which the provider participation fee was to have been received by the Department as described in subsection (c) above.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances to qualified facilities of medical assistance services. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:

A) the facility has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under

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which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the facility's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a facility which are unrelated to Department technical system problems and which result in extensive financial problems to a facility adversely impacting on its ability to serve its clients.

B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) 85 percent or more of their residents must be eligible for public assistance;

ii) for government-owned facilities, subsection (h)(1)(B)(i) may be waived if the cash flow criteria under subsection (h)(1)(A)(ii) is met; and

iii) for providers who have filed for Chapter 11 bankruptcy, subsection (h)(1)(B)(i) may be waived if the cash flow criteria under subsection (h)(1)(A)(ii) is met.

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C) the facility must file a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than sixty (60) days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0;

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;

iii) cash or other assets has been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the assessment payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.

D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow provider participation fee funds through a cash flow bond pool or financial institutions such as a commercial bank.

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E) the facility must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver that shall be due from the facility as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and

vi) such other terms and conditions that may be required by the Department.

2) A facility which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the facility not meeting the above criteria, upon a

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sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received within ten (10) working days of the date of the Department's notification of the provider participation fee due for the subject quarter as described in subsection (c) above. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests by certified mail postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the facility.

B) The facility shall be notified by the Department, in writing, of the Department's decision with regard to the request for institution of delayed payment provisions.

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An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet the terms and conditions of the agreement. In the event the facility fails to meet the terms and conditions of the agreement, the agreement shall be considered null and void and such penalities shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above is 1.5 or less and the facility meets the criteria in (h)(1)(A) and (B). Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) above.

6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms

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and conditions of any current delayed payment agreement have been satisfied. The waiver of penalties described in subsection (h)(3) shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Disbursements from the Fund

1) Disbursements from the Funds shall be made only:

A) for facility expenditures made under Title XIX of the Social Security Act;

B) for the reimbursement of monies collected by the Department from facilities through error or mistake;

C) for payment of administrative expenses incurred by the Department or its agent in performing the activities authorized by subsections (b), (c), (d), (e) and (f) above; and

D) for payments of any amounts which are reimbursable to the federal government for payments from these Funds which are required to be paid by State warrant. Disbursements from these Funds shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Department.

2) Disbursements from the Fund are conditional on:

A) expiration of the time limitations for reconsiderations requested by facilities under subsection (e)(1) above; and

B) the availability of sufficient monies in the Funds to make the payments required after the quarterly reconciliation determined

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under subsection (e)(2) above and the annual audit reconciliation determined under subsection (l) below.

j) Court Orders. If one or more facilities file suit in any court challenging any part of this Section, payments to facilities under this Section shall be made only to the extent that sufficient monies are available in the appropriate Fund and only to the extent that any monies in the Fund are not prohibited from disbursement under any order of the Court.

k) Federal Approval. Payments under the disbursement methodology described in this Section are subject to approval by the federal government in an appropriate State plan amendment. Fees under this Section are conditioned on the disbursement methodology being approved by the federal government in an appropriate State plan amendment.

l) Annual Audit/Reconciliation

1) The Department shall conduct an annual review and reconciliation of the provider participation fees paid by facilities within 9 months from the end of the State fiscal year in which the fee described in subsection (b) is due. The purpose of the reconciliation shall be to adjust the provider participation fees paid by a facility to reflect:

A) the actual services provided by the facility to clients of the Medical Assistance Program during the period to which the provider participation fee relates; and

B) the payments actually received by the facility related to those services during the period to which the provider participation fee relates.

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2) Where the estimated utilization of services or gross receipts as determined and utilized by the Department in the calculation of fees due under subsection (b) does not reflect the facility's actual utilization or actual gross receipts during the period to which the provider participation fee relates, the Department shall recalculate the facility's provider participation fee in accordance with subsection (b), using the facility's actual utilization and actual gross receipts for the period to which the provider participation fee relates.

A) If the recalculation indicates that the facility should have been required to pay, but did not pay, a higher provider participation fee based upon actual utilization, the facility shall be required to pay to the Fund within 60 days of the date of notification from the Department that monies are owed to the Department, the difference between the provider participation fee amount actually paid and the provider participation fee amount which should have been paid.

B) If the recalculation indicates that the facility paid a total provider participation fee during the twelve-month period which exceeded that which the facility should have been required to pay based upon actual utilization, the Department shall refund within 60 days of the date of notification from the Department that monies are due the facility to the facility the difference between the amount the facility actually paid and the amount of the provider participation fee the facility should have paid.

3) In no event shall the payments to a facility, less the fees paid by the facility under

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subsections (b) and (c) above, equal less than the payments from the facility's State fiscal year 1991 weighted average payment rates reduced by 5% unless current rates are lowered by the Inspection of Care survey or rates are reduced due to lowered costs as reported in the cost report used to calculate the current rate.

4) Amounts recovered from a facility shall be credited to the appropriate Fund. A facility is entitled to recover amounts paid to the Department and to receive refunds and payments from the Department under this Section only to the extent that monies are available in the appropriate Fund.

5) Upon notification of the results of the Department's annual audit/reconciliation, each facility shall have the right to reconsideration of the results of such annual audit/reconciliation. Such requests for reconsideration must be received in writing within thirty (30) calendar days of the date of the Department's notification of the fee due. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the facility of the results of the review within 30 days of the receipt of all required review material. If the facility fails to request a reconsideration pursuant to this subsection, the Department's determination shall be final.

m) Applicability

The requirements of this Section shall apply only as long as federal funds under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) are available to match the fees collected and disbursed under this Section and only as long as reimbursable expenditures are matched at the Federal Medicaid percentage of a least 50 percent. Whenever the Department is informed

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that federal funds are not available for these purposes, or shall be available at a lower percentage, this Section shall no longer apply and the Department shall promptly refund to each facility the amount of money currently in the Funds that has been paid by the facility, plus any investment earnings on that amount.

n) Definitions

1) "Actual gross receipts" means the gross receipts, as determined and reported by the Department, for services provided during the previous fiscal year which have been paid within nine (9) months from the end of such previous State fiscal year (for example, services provided in fiscal year 1991 and paid no later than March 31, 1992, for fees described in subsection (b) which are imposed in State fiscal year 1992; services provided in fiscal year 1992 and paid no later than March 31, 1993, for fees described in subsection (b) which are imposed in State fiscal year 1993; etc.).

2) "Actual utilization" means the actual utilization of services provided during the State fiscal year in which the fee described in subsection (b) is due and which have been paid within nine (9) months from the end of such State fiscal year (for example, services provided in fiscal year 1992 and paid no later than March 31, 1993 for fees imposed in State fiscal year 1992; services provided in fiscal year 1993 and paid no later than March 31, 1994 for fees imposed in State fiscal year 1993; etc.).

3) "Estimated rate year utilization" means the facility's project utilization for the State fiscal year in which the fee described in subsection (b) is due (for example, fiscal year 1992 for fees imposed in State fiscal year 1992, fiscal year 1993 for fees imposed in State fiscal year 1993, etc.).

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4) "Facility" means a Medicaid certified intermediate care facility for the developmentally disabled or intermediate care facility for the developmentally disabled of 16 beds or less, skilled or intermediate nursing facility, including county nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code, but shall not include state-operated facilities or campus facilities as defined in Section 140.583.

5) "Fee" means a provider participation fee paid by facilities under this Section.

6) "Fund" means the Medicaid Developmentally Disabled Provider Participation Fee Trust Fund and/or Medicaid Long Term Care Provider Participation Fee Trust Fund.

7) "Gross Receipts" means all annualized payments for medical services delivered under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and Article V of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 5-1 et seq.) and shall mean any and all payments made by the Department, or a Division thereof, to a facility certified to participate in the Medical Assistance Program, for services rendered eligible for Medical Assistance under Article V of the Public Aid Code, State regulations and the federal Medicaid Program as defined in Title XIX of the Social Security Act and federal regulations.

(Source: Added at 16 Ill. Reg. 6408, effective March 20, 1992)

Section 140.95 ~~Participation (Recodified)~~ Hospital Services Trust Fund

a) Purpose and Contents.

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1) The Hospital Services Trust Fund ("Fund") was created in the State Treasury upon enactment of Public Act 87-13. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsections (b)(1), (b)(2) and (b)(3) below;

B) All federal matching funds received by the Illinois Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund; and

D) All other monies received for the Fund from any other source, including interest earned thereon.

b) Provider Participation Fees.

1) Beginning on July 1, 1991, and ending on June 30, 1995, a fee is imposed upon each hospital in an amount equal to 50 percent of the positive difference between the hospital's anticipated annualized Medicaid spending, which shall be calculated using the estimated rate year utilization, for State fiscal year 1992 and each State fiscal year thereafter through State fiscal year 1995 excluding payments under 89 Ill. Adm. Code 148.120 and Section 5-5.02 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 5-5.02), and the hospital's total Medicaid base year spending. This fee shall be adjusted pursuant to

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the annual audit described in subsection (l) below to reflect actual annualized Medicaid spending and actual rate year utilization.

2) Beginning on July 1, 1991, and ending on June 30, 1995, a fee is imposed upon each hospital in an amount equal to 5 percent of the hospital's gross receipts for services provided during the previous State fiscal year as determined and reported by the Department. This fee shall be adjusted pursuant to the annual audit described in subsection (l) below to reflect actual Medicaid gross receipts for services provided during the previous State fiscal year.

3) Beginning on July 1, 1991, and ending on June 30, 1995, a fee is imposed upon each hospital which receives critical care access payments under subsection (d) of Section 14-8 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-8). This fee is equal to fifty (50) percent of the critical care payments as calculated in accordance with 89 Ill. Adm. Code Section 148.120(k).

c) Payment of Fees Due.

1) The fees described in subsection (b) above and shall be due and payable on a calendar quarterly basis.

2) The fees shall be payable to and collected by the Illinois Department in quarterly amounts due and received by the Department at the address specified on the Provider Participation Fee Notice described in subsection (d) on the first business day of the first calendar quarter following the quarter for which the fee is being paid, with the exception of the initial payment which shall be due on November 1, 1991. The subsequent quarterly amounts shall be due on January 1, April 1, July 1, and October 1 of each year with the final payment due on July 1, 1995. All monies collected under subsections (b) and (c) shall be deposited into the Fund.

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3) All payments received by the Department shall be credited first to any interest, second to any penalty, and then to the fee due.

d) Notification.

The Department shall notify each hospital of the results of its calculations under subsections (b) and (c) above. The notification shall be in writing and shall be submitted to the hospital at least thirty (30) days prior to the date on which the provider participation fee is due. Such calculations shall be subject to quarterly reconciliations as described in subsection (e) below and the annual audit/ reconciliation described in subsection (l) below.

e) Procedure for Reconsideration and Quarterly Reconciliation.

1) Reconsiderations. Upon notification of the results of the Department's calculations under subsections (b) and (c) above, each hospital shall have the right to reconsideration of the calculation of its provider participation fee for that quarter. Only requests for reconsideration of the assessment calculation shall be considered during the quarterly reconciliation period. All appeals based on utilization/spending estimates shall be addressed during the annual audit/ reconciliation described in subsection (l) below.

A) Requests for reconsideration must be received in writing within 30 calendar days of the date of the Department's notification of the fee due. The request shall be accompanied by written materials setting forth the grounds for reconsideration.

B) A hospital shall be required to pay its provider participation fee amount for the time period in question. In the event that a request for reconsideration results in the need for an adjustment to the fee due for the subject quarter, such adjustment shall

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be made during the quarterly reconciliation for the subject quarter.

2) Quarterly Reconciliation. A quarterly reconciliation shall be performed by the Department to make adjustments to the fees calculated by the Department under subsections (b) and (c) above. During the quarterly reconciliation, the Department shall consider all requests for reconsideration which are received in compliance with subsection (e)(1) above. The Department shall notify each hospital of the results of the quarterly reconciliation. The notification shall be in writing and shall be submitted to the hospital at least ten (10) working days prior to the date on which the subsequent provider participation fee is due. If as a result of the reconciliation, the Department determines that the amount of the reconsidered fee was incorrect, the notification shall include an adjustment to the amount of the provider participation fee which is next due. The facility shall be obligated to pay the amount shown on the reconciliation notification if that amount differs from the amount in the notification described in subsection (d).

f) Penalties.

1) Any hospital that fails to pay the fee when due or pays less than the full amount due as described in subsections (b) and (c) above, shall be assessed a penalty of ten (10) percent of the delinquency or deficiency for each month, or fraction thereof, computed on the full amount of the delinquency or deficiency, which includes any penalty accrued and not paid, from the time the fee was due.

2) Within five days from the due date, the Department will begin immediate recoupment actions against the delinquent provider by witholding the amount due from future payments. No payments will be made to the provider until the entire provider fee including any penalties is satisfied. Recoupment proceedings against the

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same provider two times in a fiscal year shall be cause for termination from the program.

3) If the provider is no longer doing business with the Department or the Department can not recover the full amount due including penalties and interest within three months of the fee due date, the Department may begin legal action to recover monies owed plus court costs.

4) The Director of the Department of Public Aid may establish delayed payment schedules for individual facilities that are unable to make timely payments under this Section due to financial difficulties. The delayed payment provisions are described in subsections (g) and (h) below.

g) Delayed Payment - Groups of Facilities

The Director may establish delayed payment of fees and/or waive the payment of interest and penalties for groups of hospitals such as disproportionate share hospitals or all other hospitals when:

1) the State delays payments to hospitals due to problems related to state cash flow, or

2) a cash flow bond pool's, or any other group financing plans', requests from providers for loans are in excess of its scheduled proceeds such that a significant number of hospitals will be unable to obtain a loan to pay the fee.

h) Delayed Payment - Individual Facilities

In addition to the provisions of subsection (g) above, the Director may waive or delay fees for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter in which the provider participation fee was to have been received by the Department as described in subsection (c) above.

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1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances to qualified providers of medical assistance services. Delayed payment provisions may be made only to qualified hospitals who meet all of the following requirements:

A) the provider has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1) and (f)(2) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a provider which are unrelated to Department technical system problems. These situations include cash flow problems which are unrelated to Department technical system problems and which result in extensive financial problems to a facility, adversely impacting on its ability to serve its clients.

B) the provider serves a significant number of clients under the medical assistance program. Significant in this instance means:

i) that the hospital must qualify as a disproportionate share hospital under 89 Ill. Adm. Code 148.120 (a)(1) through 148.120 (a)(4).

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ii) for government-owned facilities, subsection (h)(1)(B)(i) may be waived if the cash flow criteria under subsection (h)(1)(A)(ii) is met; and

iii) for providers who have filed for Chapter 11 bankruptcy, subsection (h)(1)(B)(i) may be waived if the cash flow criteria under subsection (h)(1)(A)(ii) is met.

C) the provider must file a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than sixty (60) days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0.

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation.

D) the provider must show evidence of denial of an application to borrow provider participation fee funds through a cash flow bond pool or financial institutions such as a commercial bank.

E) the provider must sign an agreement with the Department which specifies the terms and

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conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver that shall be due from the provider as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement; and

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge.

2) A hospital which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the hospital not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the hospital. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process.

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A) In order to receive consideration for delayed payment provisions, providers must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received within ten (10) working days of the date of the Department's notification of the provider participation fee due for the subject quarter as described in subsection (c) above. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests by certified mail, postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the provider.

B) The hospital shall be notified by the Department, in writing, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) may be waived upon approval of the provider's request for

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institution of delayed payment provisions. In the event a provider's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the provider fails to meet on the terms and conditions of the agreement. In the event the provider fails to meet on the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above is 1.5 or less and the hospital meets the criteria in (h)(1)(A) and (B). Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(D) above.

6) Subsequent Delayed Payment Arrangements. Once a provider has requested and received approval for delayed payment arrangements, the provider shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied. The waiver of penalties described in subsection (h)(3) shall not apply to a provider that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Disbursements from the Fund.

1) Disbursements from the Fund shall be made only:

A) for hospital inpatient, hospital ambulatory care, and disproportionate share distributive expenditures made under Title

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XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

B) for the reimbursement of monies collected by the Department from hospitals through error or mistake;

C) for payment of administrative expenses incurred by the Department or its agent in performing the activities authorized by subsections (b), (c), (d), (e) and (f) above; and

D) for payments of any amounts which are reimbursable to the federal government for payments from this Fund which are required to be paid by State warrant. Disbursements from this Fund shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Department.

2) Disbursements from the Fund are conditional on:

A) expiration of the time limitations for reconsiderations requested by hospitals under subsection (e)(1) above.

B) the availability of sufficient monies in the Fund to make the payments required by Section 14-8 of the Public Aid Code after the quarterly reconciliation determined under subsection (e)(2) above, and the annual audit reconciliation determined under subsection (l) below.

j) Court Orders.

If one or more hospitals file suit in any court challenging any part of this Section, payments to hospitals under this Section shall be made only to the extent that sufficient monies are available in the Fund and only to the extent that any monies in the Fund are not prohibited from disbursement under any order of the court.

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k) Federal Approval.

Payments under the disbursement methodology described in Section 14-8 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-8) are subject to approval by the federal government in an appropriate State plan amendment. Fees under this Section are conditioned on the disbursement methodology described in Section 14-8 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-8) being approved by the federal government in an appropriate State plan amendment.

l) Annual Audit/Reconciliation.

1) The Department shall conduct an annual review and reconciliation of the provider participation fees paid by hospitals. The purpose of the reconciliation shall be to adjust the provider participation fees paid by a hospital to reflect:

A) the actual services provided by the hospital to recipients of the Medical Assistance Program, and

B) the payments actually received by the hospital related to those services during the period to which the provider participation fee relates.

2) Where the estimated rate year utilization, anticipated annualized Medicaid spending or gross receipts as determined and utilized by the Department in the calculation of fees due under subsections (b)(1) and (b)(2) do not reflect the hospital's actual rate year utilization, actual annualized Medicaid spending or actual gross receipts during the period to which the provider participation fee relates, the Department shall recalculate the hospital's provider participation fee in accordance with subsection (b), utilizing the hospital's actual rate year utilization, actual annualized Medicaid spending and actual gross receipts for the period to which the provider participation fee relates.

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A) If the recalculation indicates that the hospital should have been required to pay, but did not pay, a higher provider participation fee based upon actual rate year utilization, actual annualized Medicaid spending or actual gross receipts during the period to which the provider participation fee relates, the hospital shall be required to pay to the Fund within 60 days of the date of notification from the Department that monies are owed to the Department the difference between the provider participation fee amount actually paid and the provider participation fee amount which should have been paid.

B) If the recalculation indicates that the hospital paid a total provider participation fee during the twelve-month period which exceeded that which the hospital should have been required to pay based upon actual rate year utilization, actual annualized spending or actual gross receipts during the period to which the provider participation fee relates, the Department shall refund within 60 days of the date of notification from the Department that monies are due to the hospital the difference between the amount the hospital actually paid and the amount of the provider participation fee the hospital should have paid.

3) In no event shall the payments to a hospital, less the fees paid by the hospital under subsections (b) and (c) above, equal less than the payments from the hospital's State fiscal year 1991 weighted average payment rates reduced by 5 percent.

4) Amounts recovered from a hospital shall be credited to the Fund. A hospital is entitled to recover amounts paid to the Department and to receive refunds and payments from the Department under this Section only to the extent that monies are available in the Fund.

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5) Upon notification of the results of the Department's annual audit/reconciliation, each hospital shall have the right to reconsideration of the results of such annual audit/reconciliation. Such requests for reconsideration must be received in writing within thirty (30) calendar days of the date of the Department's notification of the fee due. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days of the receipt of all required review material. If the hospital fails to request a reconsideration pursuant to this subsection, the Department's determination shall be final.

m) Applicability.

The requirements of this Section shall apply only as long as federal funds under Title XIX of the Social Security Act are available to match the fees collected and disbursed under this Section and only as long as reimbursable expenditures are matched at the Federal Medicaid percentage of at least 50 percent. Whenever the Department is informed that federal funds are not available for these purposes, or shall be available at a lower percentage, this Section shall no longer apply, and the Department shall promptly refund to each hospital the amount of money currently in the Fund that has been paid by the hospital, plus any investment earnings on that amount.

n) Definitions.

As used in this section, unless the context requires otherwise:

1) "Actual annualized Medicaid spending" means the actual expenditures made by the Department for services provided during the State fiscal year in which the fee described in subsection (b)(1) is due and which have been paid within nine (9) months from the end of such State fiscal year (for example, services provided in fiscal year

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1992 and paid no later than March 31, 1993 for fees imposed in State fiscal year 1992; services provided in fiscal year 1993 and paid no later than March 31, 1994 for fees imposed in State fiscal year 1993; etc.). Such expenditures shall not include disproportionate share payments, targeted access payments, critical care access payments or uncompensated care payments.

2) "Actual gross receipts" means the gross receipts, as determined and reported by the Department, for services provided during the previous fiscal year which have been paid within nine (9) months from the end of such previous State fiscal year (for example, services provided in fiscal year 1991 and paid no later than March 31, 1992, for fees described in subsection (b)(2) which are imposed in State fiscal year 1992; services provided in fiscal year 1992 and paid no later than March 31, 1993, for fees described in subsection (b)(2) which are imposed in State fiscal 1993; etc.).

3) "Actual rate year utilization" means the actual utilization of services provided during the State fiscal year in which the fee described in subsection (b)(1) is due and which have been paid within nine (9) months from the end of such State fiscal year (for example, services provided in fiscal year 1992 and paid no later than March 31, 1993 for fees imposed in State fiscal year 1992; services provided in fiscal year 1993 and paid no later than March 31, 1994 for fees imposed in State fiscal year 1993; etc.).

4) "Anticipated annualized Medicaid spending" means the Department's estimate of expenditures which will be made to the hospital for services provided in the State fiscal year in which the fee described in subsection (b)(1) is due (for example, fiscal year 1992 for fees imposed in State fiscal year 1992, fiscal year 1993 for fees imposed in State fiscal year 1993, etc.). Such expenditures shall not include disproportionate share payments, targeted access payments, critical care access payments or uncompensated care payments.

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5) "Estimated rate year utilization" means the hospital's projected utilization for the State fiscal year in which the fee described in subsection (b)(1) is due (for example, fiscal year 1992 for fees imposed in State fiscal year 1992, fiscal year 1993 for fees imposed in State fiscal year 1993, etc.).

6) "Fund" means the Hospital Services Trust Fund.

7) "Gross Receipts" means all payments for medical services delivered under Title XIX of the Social Security Act and Articles V, VI and VII of the Public Aid Code and shall mean any and all payments made by the Department, or a Division thereof, to a Medical Assistance Program provider certified to participate in the Illinois Medical Assistance Program, for services rendered eligible for Medical Assistance under Articles V, VI and VII of the Public Aid Code, State regulations and the federal Medicaid Program as defined in Title XIX of the Social Security Act and federal regulations.

8) "Hospital" means any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, which is located in the State and is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act or any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located, and is required to submit cost reports to the Department under 89 Ill. Adm. Code 148, but shall not include the University of Illinois Hospital Act or a county hospital in a county of over 3 million population.

9) "Total Medicaid Base Year Spending" means the hospital's State fiscal year 1991 weighted average payment rates, excluding payments made under 89 Ill. Adm. Code 148.120 and Section

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5-5.02 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 5-5.02), reduced by 5 percent and multiplied by the hospital's estimated rate year utilization.

10) "Weighted Average Payment Rate" means the hospital's payment rates for specific services, divided by the hospital's utilization for those specific services, plus any disproportionate share and outlier adjustments and less any third party liability payments.

o) Fee Assurances

1) Notwithstanding any provision of any rule of the Illinois Department of Public Aid, if either of the following events occurs:

A) Federal funds under Title XIX of the Social Security Act are no longer available to match the fees collected and disbursed under Section 14-3 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-3) or the State's expenditures are matched at a Federal Medicaid percentage of less than 50%; or

B) The State Plan amendment, in substantially the form submitted to the Health Care Financing Administration ("HCFA") prior to October 1, 1991, implementing the disbursement methodology set forth in Section 14-8 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-8) is disapproved by HCFA.

2) Then the Department shall:

A) Make payments to hospitals in an amount commensurate with the payment rates that would have been paid pursuant to Section 14-8 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-8), the proposed State Plan amendment, and rules implementing such Section for services provided to Medicaid

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recipients during the period for which fees have been collected under Section 14-3 of the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 14-3) (fees due on the first business day of one quarter are considered collected for the previous quarter pursuant to subsection (c)(2) above); or

B) If the Department cannot make payments at the level described in subsection (2)(A) above, refund to the hospital the hospital's fee, or portion thereof, which has not been recouped by the hospital through the payment rates as described in subsection (2)(A) above. The difference between the actual payments made to the hospital and the payments that would have been made to the hospital based on the hospital's total Medicaid base year spending shall be considered the amount of the fee recouped by the hospital.

(Source: Added at 16 Ill. Reg. 6408, effective March 20, 1992)

SUBPART E: GROUP CARE

Section 140.530 Basis of Payment for ~~Group~~ Long Term Care Services

a) The amount approved for payment for ~~group care~~ long term care services is based on the type and amount of services required by and actually being furnished to a ~~recipient~~ resident and is determined in accordance with the Department's rate schedule.--~~The approved Department rate shall not exceed the charges to nonrecipients.~~

~~b) However, the Department may approve a rate exceeding the rate schedule for a period not to exceed 60 days, if necessary to effect hospital discharge.~~

~~c)~~b) Costs not related to patient care, as well as costs in excess of those required for the efficient and economical delivery of care, will not be reimbursed.

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Section 140.530 Basis of Payment for ~~Group~~ Long Term Care Services (Cont'd)

~~d)~~c) Payment for long term care services is on a per diem basis. In determining the number of days for which payment can be made, the day of admission to the facility is counted. The day of discharge from the facility is not counted unless it is the day of death, and death occurs in the facility, or a reserved bed has been authorized for that day.

~~e)~~d) Definitions

1) "Allowable costs" are those which are appropriate patient care expenditures as defined in the Department's Rules.

2) "Reasonable costs" for specific types of expenditures are costs which conform to the Department's Rules and do not exceed guidelines established by the Office of Health Finance ~~of the Department of Public Health~~.

3) "Reimbursable costs" are determined by application of statistical standardizations of allowable costs for all provider within various defined groups to the costs of individual providers within such groups.

(Source: Amended at 16 Ill. Reg. 6408, effective March 20, 1992)

Section 140.538 Special Costs

a) Transportation -- The costs of transportation that is medically necessary and is of the type reimbursed by Public Aid in addition to the routine rate is not allowable. Other types of patient related transportation costs should be classified as either administrative costs or activity costs and are allowable.

b) Ancillary Services -- are not an allowable expenditure. Ancillary services are those services which are not explicitly required by licensing requirements. Accordingly, the definition of ancillary service differs by licensure type, particularly between SNF and ICF, as compared to ICF/MR facilities.

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Section 140.538 Special Costs (Cont'd)

c) For SNF or ICF, the following are ancillary services: occupational therapy by a licensed therapist, recreational therapy by a licensed therapist, dental care, work-related programs, rehabilitation by licensed personnel, pharmacy (other than "group care restricted"), psychological services (evaluation and diagnosis/behavior modification), and academic education by licensed personnel.

d) These services, when offered by the above practitioners are ancillary services whether they are offered in the facility or outside the facility. Note, this does not include consultants or services offered by unlicensed personnel within the facility even if they relate to the above program areas.

e) In an ICF/MR or SNF Pediatric facility the following services are ancillary: physician care, dental care -- except for dental screening, work-related programs (other than Level I Developmental Training and Level II Developmental Training as defined in Section 140.647, Description of Day Programming Service Levels), pharmacy (other than "group care restricted"), academic education, and any service for which the individual practitioner bills the Department directly or any service for which the Provider directly bills another Department or another governmental unit, including local school districts.

f) It is the responsibility of the individual provider to obtain prior approval before rendering ancillary services. Ancillary providers must be enrolled with the Department.

g) Oxygen in excess of one tank per patient per month is reimbursed directly rather than as part of the per diem. In order to submit claims the facility must be enrolled as a provider of oxygen.

h) Barber and Beauty Shops -- Costs associated with barber and beauty shops are not allowable.

i) Coffee and Gift Shops -- Costs associated with coffee and gift shops are not allowable.

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Section 140.538 Special Costs (Cont'd)

j) Assessment fees required by Public Act 87-13 to be paid to the Department of Public Aid are not an allowable cost for reimbursement purposes. This fee must be reported on the cost report Schedule V, Section E, Special Cost Centers, Line 42, Other Cost.

(Source: Amended at 16 Ill. Reg. 6408, effective March 20, 1992)

Section 140.552 Nursing and Program Costs

Beginning July 1, 1991, ~~Nursing~~ nursing and program costs (mostly salary costs for direct care staff, but also including some supplies and other related expenses, see Section 140.532) will be updated by DRI average hourly earnings production workers for nursing and personal care facilities. ~~North Central Region experienced and projected, adjusted to Illinois experience as follows:~~

~~a) The rate of wage inflation for Illinois nursing homes from calendar year ending 1976 through the most current reporting period will be determined for registered nurses, licensed practical nurses and nurse's aides. This rate of inflation, however, will be adjusted to exclude any changes caused by minimum wage over and above the underlying rate of inflation. The impact of minimum wage will continue to be calculated separately as specified in Section 140.555.~~

~~b) The rate of wage inflation as calculated in subsection (a) above will be compared to the experienced DRI average hourly earnings production workers for nursing and personal care facilities North Central Region increase for the same period.~~

~~c) The resultant factor will become an adjuster which is applied to DRI average hourly earnings production workers for nursing and personal care facilities North Central Region projections from the year of the cost reports to the rate year.~~

(Source: Amended at 16 Ill. Reg. 6408, effective March 20, 1992)

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Section 140.562 Nursing Costs

a) The Department reimburses for nursing costs based on geographic area in which the facility is based, and the level of care the facility (or distinct part thereof) is licensed to provide. Nursing costs also include an increment to reimburse for patients requiring skilled care for differences in support cost areas statistically related to variable patient conditions. For residents in Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF), the Department reimburses for nursing costs according to Sections 140.900 through 140,907; for residents in Skilled Nursing Facilities for Pediatrics (SNF/PED) or Intermediate Care Facilities for the Medically Retarded (ICF/MR), the Department reimburses for nursing costs according to Sections 140.850 through 140.885.

b) For the period July 1, 1986, through December 31, 1986, no facility's rate of reimbursement for Nursing Services shall be less than 90% of the rate of reimbursement for Nursing Services that facility received for the period January 1, 1986, through June 30, 1986.

c) For the period July 1, 1986 through December 31, 1986, the Department shall perform an additional computation for the rate of reimbursement for Nursing Services.

1) For intermediate and skilled care facilities, the additional computation is as follows:

A) Unadjusted nursing rates will be computed according to Section 140.905.

B) The unadjusted nursing rate will be compared to 90 percent of the previous effective rate for Nursing Services for each facility. The greater of the two rates will be the "hold harmless" nursing rate.

C) The mean difference between the "hold harmless" nursing rates and the previous effective nursing rates will be computed for each HSA area. This difference will be an interim base for the HSA area.

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Section 140.562 Nursing Costs (Cont'd)

D) The adjusted nursing rate will be the sum of the "hold harmless" nursing rate and the interim base rate.

2) For intermediate and skilled care facilities for the developmentally disabled, the additional computation is as follows:

A) Unadjusted nursing rates will be computed according to Section 140.885.

B) The mean difference between the unadjusted nursing rates and the previous effective nursing rates will be computed for each licensure group. This difference will be an interim base rate for the licensure group.

C) The adjusted nursing rate will be the sum of the unadjusted nursing rate and the interim base rate.

d) For the period January 1, 1987 through June 30, 1987, the nursing rate component for any skilled and intermediate care facility (not including facilities for the developmentally disabled) will be the higher of either the rate for the prior rate period (July 1, 1986 through December 31, 1986) or the rate as calculated according to Subpart G.

e) For the period January 1, 1987 through June 30, 1987, the nursing rate component for facilities for the developmentally disabled will be the same as for the prior rate period (July 1, 1986 through December 31, 1986).

f) For the period July 1, 1987, through December 31, 1987, the nursing rate component (updated for wage inflation from January 1, 1987, through January 1, 1988, as computed in Sections 140.909(b)(1)(A)(iv) and (v)) for long term care facilities for the developmentally disabled will be the same as for the prior rate period (January 1, 1987, through June 30, 1987).

g) For the period January 1, 1988 through June 30, 1988, the nursing rate component for facilities for the

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Section 140.562 Nursing Costs (Cont'd)

developmentally disabled will be the same as for the prior rate period (July 1, 1987 through December 31, 1987).

~~h) For the period July 1, 1990, through June 30, 1992, nursing rates established for all long term care facilities with a SNF, ICF, or ICF-MI license shall be increased by a 7.1% nursing wage adjustment factor.~~

(Source: Amended at 16 Ill. Reg. 6408, effective March 20, 1992)

Section 140.569 Clients With Exceptional Care Needs

a) Exceptional Care Program

1) Pursuant to Section 5-5A of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 5-5A), the Department may make payments to nursing facilities which substantially meet licensure and certification requirements as may be prescribed by the Department of Public Health. For purposes of this Section, substantial compliance shall mean compliance with eligibility standards required of providers under the Department's QUIP program, Section 140.525(b).

2) The Department may, but is not required to, enter into contracts with facilities offering exceptional medical services, referred to herein as Providers.

3) Exceptional medical care is defined as the level of medical care required by persons ~~who are medically stable and ready for discharge from a hospital but~~ who require a multi-disciplinary level of care for physician, nurse and ancillary specialist services with exceptional costs related to extraordinary equipment and/or supplies that have been determined to be a medical necessity. Beginning July 1, 1991, this may apply to Medicaid patients who are being discharged from the hospital or Medicaid eligible residents transitioning from Medicare to Medicaid while in the nursing facility. This includes but

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Section 140.569 Clients With Exceptional Care Needs (Cont'd)

is not limited to persons with acquired immune deficiency syndrome (AIDS) or related condition, head-injured persons, and ventilator dependent persons. In order for a person to be assessed for exceptional care placement the hospital must be entitled to receive Medicaid reimbursement as the primary source of payment for this person. ~~Consideration may be given to those residents currently residing in a facility who require a multi-disciplinary level of care and meet criteria as stated in subsection (j)(2).~~

4) The Department shall negotiate with nursing home providers and enter into a contract with Providers. The rate of payment will be reasonable and adequate to meet the costs incurred by the facilities providing exceptional care. Providers may negotiate separate facility wide rates for separate types of care. In determining the rate of payment to a facility, the Department shall take into account cost information submitted by the facility.

b) Exceptional Care Contract Requirements

The Department may enter into a contract for exceptional care services only if the Provider agrees to the following conditions:

1) The Provider will maintain separate records regarding costs related to the care of the exceptional care residents, reporting them in the ancillary section of the Department Long Term Care Facility Cost Reports.

2) The facility must demonstrate the capacity and capability to provide exceptional care as documented by Department of Public Health and Department of Public Aid records.

3) The Provider must maintain and provide documentation demonstrating:

A) Adherence to staffing requirements as set out in subsection (c);

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B) Adherence to staff training requirements as set out in subsection (d);

C) Validity of written agreements as required in subsection (e);

D) Presence of emergency policy and procedures as set out in subsection (f);

E) Medical condition of the resident; and

F) Care, treatments and services provided to the resident.

4) The Provider must have and maintain physical plant adaptations to accommodate the necessary equipment.

5) The Provider must have and maintain an emergency electrical backup system.

c) Exceptional Care Staffing Requirements

Staffing requirements for facilities providing exceptional care include:

1) A minimum of one RN on duty on the day shift, seven days per week (as required by the Department of Public Health and set out in 77 Ill. Adm. Code 300.1240). Additional RN staff may be determined necessary by the Department of Public Aid, based on the Department's review of the individual exceptional care clients' needs and/or the exceptional care needs relative to the category of services being contracted for.

2) A minimum of the required number of LPN staff (as required by the Department of Public Health and set out in 77 Ill.Adm.Code 300.1230 and 300.1240), on duty, with an RN on call, if not on duty on the evening and night shifts, seven days per week; and

3) A certified respiratory therapy technician or registered respiratory therapist, on staff or on contract with the facility, for those facilities

Section 140.569 Clients With Exceptional Care Needs (Cont'd)

serving ventilator dependent residents or residents requiring respiratory therapy services.

d) ~~Exceptional Care Staff Training Requirements for Facilities Providing Ventilator Dependent Care~~ Training requirements for facilities providing exceptional care for ventilator dependent residents include:

1) At least one of the full-time professional nursing staff members has successfully completed a course in the care of ventilator dependent individuals and the use of ventilators, conducted and documented by a certified respiratory therapy technician or registered respiratory therapist (as certified/registered by the Department of Professional Regulation) or a qualified registered nurse who has at least one year experience in the care of ventilator dependent persons, and

2) All staff caring for ventilator dependent residents must have documented inservice training in ventilator care prior to providing such care. Inservice training must be conducted at least annually by a certified respiratory therapy technician or registered respiratory therapist (as certified/registered by the Department of Professional Regulation) or a qualified registered nurse who has at least one year experience in the care of venilator dependent persons. Inservice training documentation shall include name and qualification of the inservice director, duration of presentation, content of presentation and signature and position description of all participants.

e) Exceptional Care Agreement Requirements

The Provider must have a valid written agreement with:

1) A medical equipment and supply provider which must include a service contract for ventilator equipment when accepting ventilator dependent residents;

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2) A local emergency transportation provider;

3) A local hospital capable of providing the necessary care for equipment dependent residents, when appropriate; and

4) A certified respiratory therapy technician or registered respiratory therapist, (unless a respiratory therapist is on staff within the facility) when accepting ventilator dependent residents or residents requiring respiratory therapy services.

f) Exceptional Care Emergency Policy and Procedures Requirements

The Provider must have specific written policies and procedures addressing emergency needs for residents requiring exceptional care.

g) Accessibility to Records

The Provider must make accessible to IDPA and/or IDPH all facility, resident and other records necessary to determine that the needs of the resident are being met and to determine the appropriateness of exceptional care services.

h) Contract Negotiations

1) A Provider shall notify the Department of its interest in participating in the Exceptional Care Program in writing by certified or registered mail, return receipt requested.

2) Negotiations between the Provider and the Department shall be conducted solely on an individual facility basis. Multiple facility negotiations shall not be permitted.

3) Prior to the beginning of negotiations, the Provider shall submit to the Department a completed Exceptional Care Data Sheet. The Department shall furnish such Data Sheet. The Exceptional Care Data Sheet shall require:

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Section 140.569 Clients With Exceptional Care Needs (Cont'd)

A) Identification of the types, quantities and costs of services which the Provider intends to offer;

B) A staffing plan for the area of the facility serving exceptional care residents; and

C) Documentation of the qualifications of staff serving exceptional care residents.

4) The Department shall provide each Provider which has notified the Department of its interest in participation in the Exceptional Care Program with a copy of the proposed contract provisions by mailing such proposed contract provisions to the provider. Each contract shall be for a period of one year.

i) Renewal/Nonrenewal of Exceptional Care Contracts

1) Providers desirous of renewing exceptional care contracts must contact the Department in writing sixty (60) days prior to the expiration date of the contract to express their intent to renew the contract.

2) Upon receipt of the Providers' intent to renew their contract, the Department shall open negotiations as set forth in subsection (h).

3) Providers desiring to terminate or not renew their contract shall notify the Department sixty (60) days prior to the date of termination or contract expiration. Payment for new admissions at an exceptional care rate will not be made to those Providers who do not have a valid exceptional care contract. Payment for exceptional care residents in facilities which terminate or do not renew their contracts will remain at the previous exceptional care rate until such time as the resident no longer requires exceptional care as determined by the Department's utilization review (see Contract Monitoring 2 and 3) or the resident is discharged.

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Section 140.569 Clients With Exceptional Care Needs (Cont'd)

4) It is the responsibility of a nursing home Provider to effect appropriate discharge planning for exceptional care residents when terminating or not renewing its contract. The Department agrees to assist Providers with any information available regarding appropriate placement settings.

j) Determining eligibility for exceptional care payment.

1) ~~All persons~~ A person being discharged from a hospital must be approved by an authorized Department representative prior to placement in a facility to be eligible for exceptional care payment. Medicaid eligible residents transitioning from Medicare to Medicaid while in the nursing facility must be approved by an authorized Department representative approximately 30 days prior to the date Medicaid payment will begin. ~~Excluding these residents currently enrolled in the negotiated rate program.~~

2) Beginning July 1, 1991, ~~In~~ in order for a person to be approved for exceptional care placement the cost of the person's care must be at least ~~50%~~ 25% more than the proposed admitting facility's per diem rate (capital, support and nursing components). Eligible items which may be used in computing the cost of the person's care include nursing services costs, therapy services costs, and medical equipment and supply costs. Computations for determining cost of care shall be based upon maximum allowable costs for service equipment and supplies and HSA wage rates for the proposed admitting facility as determined by the Department.

k) Provision for Patients for which a Long Term Care Placement is Unavailable

In the event placement for a patient in need of exceptional care services or skilled nursing services cannot be located, the Department shall approve payment to the hospital in which the patient is receiving services. The rate of payment to the hospital shall not exceed the average statewide long

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Section 140.569 Clients With Exceptional Care Needs (Cont'd)

term care facility per diem rate for the level of services provided.

l) Contract Monitoring

1) All utilization controls applied to exceptional care by the Department in accordance with the approved plan for medical services under Section 5-2 of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 5-2), and Title XIX of the Federal Social Security Act (42 U.S.C. 1396a) shall continue to apply to exceptional care provided under the Exceptional Care Program (Ill. Rev. Stat. 1989, ch. 111 1/2 par. 6503-5; Section 3-5 of the The Health Finance Reform Act).

2) The Department shall provide for a program of delegated utilization review and quality assurance. The Department may contract with Medical Peer Review organizations to provide utilization review and quality assurance under any contract negotiated for exceptional care.

3) The Department shall review exceptional care residents' utilization of services every ninety (90) days.

4) In the event that it is determined that the resident is no longer in need of exceptional care services, the Department shall reduce the rate of payment to the Provider to the facility's standard Medicaid per diem rate.

(Source: Amended at 16 Ill. Reg. 6408, effective March 20, 1992)

Section 140.583 Campus Facilities

a) A "campus facility" is defined as an entity which consists of a long term care facility (or group of facilities if the facilities are on the same continguous parcel of real estate) which meets all of the following criteria as of May 1, 1987:

1) The entity provides care for both children and adults.

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Section 140.583 Campus Facilities (Cont'd)

2) Residents of the entity reside in three or more separate buildings with congregate and small group living arrangements on a single campus.

3) The entity provides three or more separate licensed levels of care on the same campus. One of these licensed levels of care must be ICF/MR and the entity must receive funding from the Department of Mental Health and Developmental Disabilities. The facility must also be licensed as a child care institution by the Department of Children and Family Services (see 89 Ill. Adm. Code 404).

b) Allowable costs will be determined under the same guidelines as used for other types of facilities providing services for ICF/MR residents (see Sections 140.530 through 140.541).

c) The campus facility reimbursement rate will be determined using the following steps:

1) Determine the total allowable cost for all residential campus services. Costs for day training, education, and day care services shall not be included in the calculation of the campus facility rate.

2) Obtain the per diem cost by dividing the total allowable cost by the adjusted patient days. The adjusted patient days will be determined in accordance with Section 140.582.

3) The operating costs are adjusted for inflation. The inflation factors will be determined in accordance with the provisions of Section 140.550. The inflated per diem operating costs are added to the per diem capital costs to obtain the updated total per diem cost.

4) The updated total per diem cost is compared to the ceiling. Beginning July 1, 1991, ~~The~~ the ~~lower of the two amounts~~ prior year rate will be multiplied by .15 and added to the lower of the above two amounts to result in the prospective payment rate.

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Section 140.583 Campus Facilities (Cont'd)

5) The ceiling will be determined at 115% of the average rate being paid to the Specialized Living Centers for ICF/MR residents.

(Source: Amended at 16 Ill. Reg. 6408, effective March 20, 1992)

Section 140.835 Determination of Cap on Payments for Long Term Care (Repealed)

~~a) Semiannually each facility must determine its private rate and report it to the Department in accordance with the following procedures if the private rate is determined to be in excess of the per diem established by the Department.~~

~~1) Private rates for the period January 1 through June 30 are to be reported by October 1 of each year. Private rates for the period July 1 through December 31 are to be reported by April 1 of each year.~~

~~2) In order to determine the private pay rate the facility will use the average of charges exclusive of DD day programming charges that were actually levied against private pay residents for the applicable six month period less discounts. Do not include charges for items or services that would not be included in the per diem set by the Department.~~

~~b) Upon receipt of the semiannual report, the Department will, where applicable, take necessary steps to retroactively adjust the Departmental rate (per diem), exclusive of the DD day programming charges, so that the per diem is no greater than the private rate reported by the facility. The per diem includes the Quality Incentive Payment component of the total daily rate. The Department will then reconcile payments as necessary.~~

~~e) Any facility that fails to comply with reporting requirements as specified above shall have payments withheld until such time as it has complied.~~

(Source: Repealed at 16 Ill. Reg. 6408, effective March 20, 1992)

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NOTICE OF ADOPTED AMENDMENTS

1) The Heading of the Part: REIMBURSEMENT FOR NURSING COSTS FOR GERIATRIC FACILITIES

2) Code Citation: 89 Ill. Adm. Code 147

3) Section Numbers: Adopted Action:

147.150	Amendment
147.TABLE A	Amendment
147.TABLE B	Amendment

4) Statutory Authority: Sections 5-5.1 et seq. and 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, Ch. 23, Pars. 5-5.1 et seq. and 12-13)

5) Effective Date of Adopted Amendments: March 20, 1992

6) Does this rulemaking contain an automatic repeal date?
___Yes X No

7) Do these Adopted Amendments contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: March 20, 1992

9) Notice of Proposal Published in Illinois Register:

November 8, 1991 (15 Ill. Reg. 15940)

10) Has JCAR issued a Statement of Objections to these Adopted Amendments: No

11) Differences between proposal and final version:

Section 147.TABLE A

Subsection (a) - under title heading "Item" delete "Medications and".

Subsection (b) - under title heading "Item" delete "Medications and".

Subsection (c) - under title heading "Staff Type" for item "Restraint Management and Reduction" add "/" after "Nurse Aide".

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Subsection (d) - delete "-" after both "2"s under title heading "Level" for items "Bathing, Grooming" and "Clothing"; add "Staff" after both "Licensed"s under title heading "Staff Type" for item "Ostomy Care".

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will these Adopted Amendments replace Emergency Amendments currently in effect? Yes

14) Are there any Amendments pending on this Part? Yes

Section Numbers	Proposed Action	Illinois Register Citation
147.25	Amendment	March 20, 1992 (16 Ill. Reg. 4218)
147.50	Amendment	March 20, 1992 (16 Ill. Reg. 4218)
147.75	Amendment	March 20, 1992 (16 Ill. Reg. 4218)
147.Table D	Amendment	March 20, 1992 (16 Ill. Reg. 4218)
147.Table E	Amendment	March 20, 1992 (16 Ill. Reg. 4218)
147.Table G	Amendment	March 20, 1992 (16 Ill. Reg. 4218)
147.Table L	New Section	March 20, 1992 (16 Ill. Reg. 4218)

15) Summary and Purpose of Adopted Amendments:

Section 147.150 "Statewide Rates" - This rulemaking revises the determination of wages to allow fringe benefits to be equal to 21%; the special minimum wage factor is being extended from June 30, 1991 to June 30, 1992; and a final wage multiplier of 4.1% will be applied to wages. This change is estimated to increase the Department's aggregate expenditures for nursing facilities by $46 million in Fiscal Year 1992.

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Section 147.TABLE A "Staff Time and Allocation by Need Level" - One licensed minute has been added to each of the four ADL categories, Bathing, Clothing, Eating and Mobility for each level, two therapy minutes have been added to Occupational and Physical Therapy for level one, two additional minutes of unlicensed time have been added to Restraint Reduction and unlicensed and licensed time have been increased to a full minute each in Social Services as well as an increase of three minutes for social worker time in this category.

Section 147.TABLE B "Staff Time and Allocation for Restorative Programs" - Two licensed minutes have been added to the four restorative ADL categories, Bathing, Clothing, Eating and Mobility for levels one and two.

Because the Department is eliminating the 7.1% nursing wage adjustment factor (see 140.150) the costs associated with 147 TABLE A and B are not estimated to increase the Department's annual aggregate expenditures in Fiscal Year 1992.

16) Information and questions regarding this Adopted Amendments shall be directed to:

Name: JoAnne Jones
Bureau of Rules and Regulations

Address: Illinois Department of Public Aid
Jesse B. Harris Building II
100 South Grand Avenue East, 3rd Floor
Springfield, Illinois 62762

Telephone: (217) 524-3215

The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 147
REIMBURSEMENT FOR NURSING COSTS FOR GERIATRIC FACILITIES

Section

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section
147.TABLE C Comprehensive Resident Assessment
147.TABLE D Functional Needs and Restorative Care
147.TABLE E Service
147.TABLE F Social Services
147.TABLE G Therapy Services
147.TABLE H Determinations
147.TABLE I Activities
147.TABLE J Signatures
147.TABLE K Rehabilitation Services

AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act (Ill. Rev. Stat. 1989, ch. 111 1/2, par. 6503-1 et seq.) and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, pars. 3-1 et seq., 4-1 et seq., 5-1 et seq., 6-1 et seq., 7-1 et seq., and 12-13)

SOURCE: Recodified from 89 Ill. Adm. Code 140.900 thru 140.912 and 140.Table H and 140.Table I at 12 Ill. Reg. 6956; amended at 13 Ill. Reg. 559, effective January 1, 1989; amended at 13 Ill. Reg. 7043, effective April 24, 1989; emergency amendment at 13 Ill. Reg. 10999, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 16796, effective October 13, 1989; amended at 14 Ill. Reg. 210, effective December 21, 1989; emergency amendment at 14 Ill. Reg. 6915, effective April 19, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 9523, effective June 4, 1990, for a maximum of 150 days; emergency expired November 1, 1990; emergency amendment at 14 Ill. Reg. 14203, effective August 16, 1990, for a maximum of 150 days; emergency expired January 13, 1991; emergency amendment at 14 Ill. Reg. 15578, effective September 11, 1990, for a maximum of 150 days; emergency expired February 8, 1991; amended at 14 Ill. Reg. 16669, effective September 27, 1990; amended at 15 Ill. Reg. 2715, effective January 30, 1991; amended at 15 Ill. Reg. 3058, effective February 5, 1991; amended at 15 Ill. Reg. 7162, effective April 30, 1991; amended at 15 Ill. Reg. 9001, effective June 17, 1991; amended at 15 Ill. Reg. 13390, effective August 28, 1991; emergency amendment at 15 Ill. Reg. 16435, effective October 22, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 4035, effective March 4, 1992; amended at 16 Ill. Reg. 6479, effective March 20, 1992.

NOTE: CAPITALIZATION DENOTES STATUTORY LANGUAGE.

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NOTICE OF ADOPTED AMENDMENTS

Section 147.150 Statewide Rates

a) This Section will become effective ~~January 1, 1987~~ July 1, 1991.~~--89 Ill. Adm. Code 140.905 will no longer be utilized for determining reimbursement rates as of January 1, 1987.~~

b) Per diem reimbursement rates for nursing care in intermediate and skilled care facilities consist of six elements: variable time reimbursement, training time reimbursement, fixed time reimbursement, fringe benefit reimbursement, and reimbursement for allowable costs of supplies, consultants, medical and nursing directors, and therapies.

1) Variable Time Reimbursement. Variable nursing time is that time necessary to meet the major service needs of residents which vary due to their physical or mental conditions. Each need level or specific nursing service measured by the Resident Assessment Instrument is associated with an amount of time and staff level (Sections 147.Table A and 147.Table B). Reimbursement is developed by multiplying the time for each service by the wage(s) of the type of staff performing the service except for occupational therapy, physical therapy and speech therapy. If more than one level of staff are involved in delivering a service, reimbursement for that service will be weighted by the wage and number of minutes allocated to each staff type. When a service can be provided by either an RN or an LPN, the wage used will be weighted by the average mix of RNs and LPNs in the sample of facilities used to set rates.

A) Determination of wages. In calculating the rate, the figures used by the Department for "wages" will be determined in the following manner:

i) The mean wages for the applicable staff levels (RN's, LPN's, Nurse Aides) as reported on the cost reports and determined by geographical location will be the base.

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NOTICE OF ADOPTED AMENDMENTS

Section 147.150 Statewide Rates (Cont'd)

ii) Fringe benefits will be equal to 21%. ~~and payroll taxes will be calculated according to the statewide ratio of fringe benefits and payroll taxes to total wages measured from the sample of facilities used to set rates;~~

iii) ~~The resulting fringe benefits and payroll taxes will be added to the base;~~.

iv) This new total will then be updated for inflation from the time period for which the wage data are available to the midpoint of the rate year to recognize projected wage changes.--~~The wage inflation rate used to update wages will be determined by comparing the historical change in nursing home wages in Illinois between 1976 and the time the latest wage information is available to the change in the DRI average hourly earnings, production workers for nursing and personal care facilities index for the U.S., for the same period.~~

~~v) The resulting ratio will be applied to the projected change in the Data Resources Incorporated (DRI) average hourly earnings, production workers for nursing and personal care facilities for the U.S., between the cost report year and the midpoint of the rate year. --This yields a wage inflation rate which will be applied to the total described in subsection (c) to produce total wages by applicable staff levels and geographic location.~~

~~vi)~~v) Special minimum wage factor. For the period July 1, 1990, through June 30, ~~1991~~1992, the Department will modify the process used in subsection (b)(1)(A)(i) to determine regional mean wages for Registered Nurses (RN),

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Section 147.150 Statewide Rates (Cont'd)

Licensed Practical Nurses (LPN) and nurse aides to include a minimum wage factor. For those homes below the statewide average the wage is replaced by 90% of the statewide average. Effective July 1, 1991, a final wage multiplier of 4.1% will be applied to wages.

B) Determination of Times and Staff Levels. The times and staff levels have been assigned by a panel of administrators and nurses active in long term care. Prior time/motion studies were used to assist the panel. These times will be reviewed periodically to insure that they accurately reflect nursing practice in the State.

2) Training Time Reimbursement

Training Time Reimbursement is determined by assessed need for training, the time allotted for training and the wage rates for licensed and nurse aide staff during the rate year.

3) Fixed Time Reimbursement. Fixed or indirect nursing time is that time which does not vary with resident condition or which cannot be measured by an assessment tool. It includes such items as staff meetings, supervision, "downtime", checking physicians' orders and time spent with residents which does not vary with condition. A statewide sample of residents will be used to determine "fixed" time. The mean variable time will be computed for the sample for each level of care, and this amount subtracted from Department of Public Health Minimum Staffing Ratios plus 5% for each level of care. (Department of Public Health Minimum Staffing Ratios, which are measured in terms of time, can be found in 77 Ill. Adm. Code 300.1230). Once the "fixed" time has been determined, the minutes will be weighted at 20% licensed and 80% unlicensed time and multiplied by the appropriate wage. This amount

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Section 147.150 Statewide Rates (Cont'd)

will be added to variable time for each resident in the sample. If fixed time is less than zero minutes, then it will equal zero.

4) Vacation, Sick Leave and Holiday Time. The time to be added for vacation, sick leave and holidays will be determined by multiplying the sum of Variable and Fixed Time by 5%. This time will then be weighted by 80% unlicensed and 20% licensed wages to determine the amount to be added to the rate for these benefits.

5) Special Supplies, Consultants and the Director of Nursing.

Finally, amounts will be added for health care and program supplies, consultants required by Department of Public Health (including the Medical Director), and the Director of Nursing. (A list of consultants required by the Department of Public Health can be found in 77 Ill. Adm. Code 300.830).

A) Supplies will be updated for inflation using the General Services Inflator (see 89 Ill. Adm. Code 140.551). A standard amount by level of care will be allocated for supplies. This amount will be determined based on the ratio of median updated supply costs by region to median costs for variable and fixed time by level of care (SNF/ICF) by region.

B) The same analysis will be used to determine an amount for Consultants (including Medical Director) and the Director of Nursing. However, these costs will be updated with the wage inflation rate.

6) Therapies. Reimbursement for physical therapy, occupational therapy, and speech therapy will not be based upon individual resident need assessments, but upon the total therapy program days the facility provided to Medicaid residents over the six-month period prior to and including

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Section 147.150 Statewide Rates (Cont'd)

the resident assessment date. These therapy days, by therapy type and level (see Table H) will be associated with staff time per day as shown in Table H and staff wages to produce a per diem rate for each of the three therapy types.

c) Determination of Facility Rates.

1) The rate each facility receives will be determined by the assessed needs of residents the facility serves. Effective January 1, 1990, nurses from Department of Public Aid (DPA) will conduct an assessment of 100% of the Medicaid residents by level of care in each home annually. ~~The inspection of care (IOC) assessment will be conducted concurrently with the QUIP assessment if the facility chooses to participate in QUIP.~~--The assessment will be conducted during the four month period prior to the annual nursing IOC rate adjustment date. The needs of the residents in the sample will be assessed with the Resident Assessment Instrument. An amount for each resident will be calculated by multiplying the number of minutes from the assessment by the appropriate wage/wages for each assessment item (see (a) above), adding the appropriate amount for fixed time (see (b) above) and amounts for vacation, sick and holiday time (see (c) above), supplies, consultants, and the Director of Nursing, (see (d) above). The average of the rates for residents assessed will become the facility's per diem reimbursement rate for each Medicaid patient in the facility effective on the facility's annual nursing IOC rate adjustment date.

2) A copy of the Resident Assessment will be left with the facility upon completion.

d) Adjustment in Instrument. Residents assessed as being in need of a service but is not receiving the required service will be scored soley as need not met.

e) An interim IOC may be requested by a facility by notifying, in writing, the Bureau of Long Term Quality

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NOTICE OF ADOPTED AMENDMENTS

Section 147.150 Statewide Rates (Cont'd)

Care Bureau Chief within 180 days of the exit date of the last IOC. The following criteria shall be met before a request for an interim IOC can be made. A 25% or greater turnover in Medicaid residents since the last IOC or there has been a 7% or greater increase in the average per patient care time. The request for the interim IOC shall contain a full explanation of why the facility meets the criteria and must include any documentation relevant to the request. The facility will be notified within 45 days from the date the request is received of whether an interim IOC will be conducted. If approved, the Bureau will conduct a full IOC within 60 days of the written approval decision. Upon reassessment, an amended 2700 will be forwarded to the DPA. Upon receipt of the amended 2700 the facility's rate will become effective for the final six months of that facility's rate year.

f) If the interim IOC is scheduled to take place during the period when the next annual IOC is scheduled, only one IOC will be done. The rate that results will apply for the 18 month period which begins with the effective date of the interim IOC rate.

(Source: Amended at 16 Ill. Reg. 6479, effective March 20, 1992)

Section 147.TABLE A Staff Time and Allocation by Need Level

a) The following reimbursement times, allocations, and need levels apply for all reimbursement periods commencing on January 1, 1988, through June 30, 1989.

Item	Level	Time	Allocation	Staff Type
Bathing, Grooming	0	6		Nurse Aide
	1	12		Nurse Aide
	2	22		Nurse Aide
Clothing	0	4		Nurse Aide
	1	10		Nurse Aide
	2	20		Nurse Aide

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Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
Eating	0	6		Nurse Aide
	1	15		Nurse Aide
	2	39		Nurse Aide
	3	39		Licensed Staff
Mobility	0	5		Nurse Aide
	1	12		Nurse Aide
	2	14		Nurse Aide
Continence	0	2		
	1	14		Nurse Aide
	2	18		Nurse Aide
	3	22		Nurse Aide
Psycho-Social Care	0	12		Nurse Aide
	1	22	17.5/4.5	Nurse Aide/ Licensed Staff
	2	28	19.5/8.5	Nurse Aide/ Licensed Staff
	3	36	35/1	Nurse Aide/ Licensed Staff
Appliances	0	0		
	1	6	5/1	Nurse Aide/ Licensed Staff
	2	12	10/2	Nurse Aide/ Licensed Staff
Catheters	0	0		
	1	12	6/6	Nurse Aide/ Licensed Staff
	2	14		Licensed Staff
Pressure Ulcer Care				
Decubitus-Care	0	0		
	1	8		Licensed Staff
	2	20		Licensed Staff
	3	0	0/0	
	4	0	0/0	
Pressure Ulcer Prevention				
Decubitus-Prevention	0	0		Nurse Aide/
	1	8	6/2	Licensed Staff

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Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
Pressure Ulcer Prevention				
~~Decubitus Prevention~~	2	14	12/2	Nurse Aide/ Licensed Staff
Wound Care	0	0		
	1	6		Licensed Staff
	2	18		Licensed Staff
Injections	0	0		
	1	1		Licensed Staff
	2	4.5		Licensed Staff
Intravenous, Clysis	0	0		
	1	4		Licensed Staff
	2	8		Licensed Staff
Lab Specimen	0	0		
	1	1	.5/.5	Nurse Aide/ Licensed Staff
	2	2	1/1	Nurse Aide/ Licensed Staff
	3	10	5/5	Nurse Aide/ Licensed Staff
Speech - Language Pathology and Audiology	0	0		
	1	8		Therapist
~~Medications and~~ Medication Monitoring	0	12		Licensed Staff
	1	14		Licensed Staff
	2	16		Licensed Staff
	3	18		Licensed Staff
Occupational Therapy	0	0		
	1	14		Therapist
	2	14	13/1	COTA/Therapist
	3	14	13/1	Nurse Aide/ Therapist
Ostomy Care	4	1		Therapist
	0	0		
	1	6		Licensed Staff
	2	13		Licensed Staff

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Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
Physical Therapy	0	0		
	1	14		Therapist
	2	14	13/1	PTA/Therapist
	3	14	13/1	Nurse Aide/ Therapist
	4	1		Therapist
Respiratory Therapy	0	0		
	1	17	15/2	Nurse Aide/ Licensed Staff
	2	25	5/20	Nurse Aide/ Licensed Staff
Tracheostomy Care	0	0		
	1	6		Licensed Staff
	2	13		Licensed Staff
Suctioning	0	0		
	1	5		Licensed Staff
	2	30		Licensed Staff
Passive Range of Motion	0	0		
	1	7		Nurse Aide
	2	14		Nurse Aide
Discharge Planning	0	0		
	1	10		Licensed Staff
Health and Fitness	0	0		
	1	4	3/1	Nurse Aide/ Licensed Staff
	2	5	3/2	Nurse Aide/ Licensed Staff
	3	4	3/1	Nurse Aide/ Licensed Staff
Activities	0	10		Nurse Aide
Grooming	0	3		Nurse Aide

Agency Note: level "0" carries no reimbursement potential when accompanied by "0" time. Level "0" provides reimbursement for every facility when accompanied with time. Such time becomes a facility's base rate for every resident.

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Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

b) The following reimbursement times, allocations, and need levels apply for all reimbursement periods commencing on July 1, 1989 through December 31, 1990.

Item	Level	Time	Allocation	Staff Type
Bathing, Grooming	0	6		Nurse Aide
	1	12		Nurse Aide
	2	22		Nurse Aide
Clothing	0	4		Nurse Aide
	1	10		Nurse Aide
	2	20		Nurse Aide
Eating	0	6		Nurse Aide
	1	15		Nurse Aide
	2	39		Nurse Aide
	3	39		Licensed Staff
Mobility	0	5		Nurse Aide
	1	12		Nurse Aide
	2	14		Nurse Aide
Continence	0	2		
	1	14		Nurse Aide
	2	19.6		Nurse Aide
Psycho-Social Care	0	12		Nurse Aide
	1	28	19.5/8.5	Nurse Aide/ Licensed Staff
Appliances	0	0		
	1	7	6/1	Nurse Aide/ Licensed Staff
Catheters	0	0		
	1	12.1	6/6.1	Nurse Aide/ Licensed Staff
Pressure Ulcer Care				
~~Decubitus Care~~	0	0		
	1	8		Licensed Staff
	2	20		Licensed Staff
	3	0	0/0	
	4	0	0/0	

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
Pressure Ulcer Prevention				
~~Decubitus Prevention~~	0	0		Nurse Aide/
	1	8	6/2	Licensed Staff
	2	14	12/2	Nurse Aide/ Licensed Staff
Wound Care	0	0		
	1	6		Licensed Staff
	2	18		Licensed Staff
Injections	0	0		
	1	1		Licensed Staff
	2	4.5		Licensed Staff
Intravenous, Clysis	0	0		
	1	4		Licensed Staff
	2	8		Licensed Staff
Lab Specimen	0	0		
	1	1	.5/.5	Nurse Aide/ Licensed Staff
	2	2	1/1	Nurse Aide/ Licensed Staff
	3	10	5/5	Nurse Aide/ Licensed Staff
Speech - Language Pathology and Audiology	0	0		
	1	0		Therapist
~~Medications and~~ Medication Monitoring	0	12.8		Licensed Staff
	1	16.1		Licensed Staff
Occupational Therapy	0	0		Nurse Aide/
	1	~~13~~14	13/1	Therapist
Ostomy Care	0	0		
	1	6		Licensed Staff
	2	13		Licensed Staff
Physical Therapy	0	0		
	1	~~13~~14	13/1	Nurse Aide/ Therapist

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
Respiratory Therapy	0	0		
	1	17	15/2	Nurse Aide/ Licensed Staff
	2	25	5/20	Nurse Aide/ Licensed Staff
Tracheostomy Care	0	0		
	1	6		Licensed Staff
	2	13		Licensed Staff
Suctioning	0	0		
	1	5		Licensed Staff
	2	30		Licensed Staff
Passive Range of Motion	0	0		
	1	11.8		Nurse Aide
Discharge Planning	0	0		
	1	10		Licensed Staff
Health and Fitness	0	0		
	1	4	3/1	Nurse Aide/ Licensed Staff
Activities	0	10		Nurse Aide
Grooming	0	3		Nurse Aide

c) The following reimbursement times, allocations, and need levels apply for all reimbursement periods commencing on ~~or after~~ January 1, 1991 through June 30, 1991.

Item	Level	Time	Allocation	Staff Type
Bathing, Grooming	0	6		Nurse Aide
	1	12		Nurse Aide
	2	22		Nurse Aide
Clothing	0	4		Nurse Aide
	1	10		Nurse Aide
	2	20		Nurse Aide

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
Eating	0	6		Nurse Aide
	1	15		Nurse Aide
	2	39		Nurse Aide
	3	39		Licensed Staff
Mobility	0	5		Nurse Aide
	1	12		Nurse Aide
	2	14		Nurse Aide
Continence	0	2		
	1	14		Nurse Aide
	2	19.6		Nurse Aide
Psycho-Social Care	0	12		Nurse Aide
	1	28	19.5/8.5	Nurse Aide/ Licensed Staff
Appliances	0	0		
	1	7	6/1	Nurse Aide/ Licensed Staff
Catheters	0	0		
	1	12.1	6/6.1	Nurse Aide/ Licensed Staff
Pressure Ulcer Care ~~Decubitus Care~~	0	0		
	1	8		Licensed Staff
	2	20		Licensed Staff
	3	0	0/0	
	4	0	0/0	
Pressure Ulcer Prevention ~~Decubitus Prevention~~	0	0		Nurse Aide/
	1	8	6/2	Licensed Staff
	2	14	12/2	Nurse Aide/ Licensed Staff
Wound Care	0	0		
	1	6		Licensed Staff
	2	18		Licensed Staff

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
Injections	0	0		
	1	1		Licensed Staff
	2	4.5		Licensed Staff
Intravenous, Clysis	0	0		
	1	4		Licensed Staff
	2	8		Licensed Staff
Lab Specimen	0	0		
	1	1	.5/.5	Nurse Aide/ Licensed Staff
	2	2	1/1	Nurse Aide/ Licensed Staff
	3	10	5/5	Nurse Aide/ Licensed Staff
Speech - Language Pathology and Audiology	0	0		
	1	0		Therapist
Medications and Medication Monitoring	0	12.8		Licensed Staff
	1	16.1		Licensed Staff
	2	18.1		Licensed Staff
Occupational Therapy	0	0		Nurse Aide/
	1	~~13~~14	13/1	Therapist
Ostomy Care	0	0		
	1	6		Licensed Staff
	2	13		Licensed Staff
Physical Therapy	0	0		
	1	~~13~~14	13/1	Nurse Aide/ Therapist
Respiratory Therapy	0	0		
	1	17	15/2	Nurse Aide/ Licensed Staff
	2	25	5/20	Nurse Aide/ Licensed Staff
Tracheostomy Care	0	0		
	1	6		Licensed Staff
	2	13		Licensed Staff

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
Suctioning	0	0		
	1	5		Licensed Staff
	2	30		Licensed Staff
Passive Range of Motion	0	0		
	1	11.8		Nurse Aide
Resident Assessment	0	2.6	.5/1.1/ .7/.3	Nurse Aide/ Licensed Staff/ Registered Nurse/Social Worker
	1	7.8	1.5/3.3/ 2.1/.9	Nurse Aide/ Licensed Staff/ Registered Nurse/Social Worker
Discharge Planning	0	0		
	1	10		Licensed Staff
Health and Fitness	0	0		
	1	4	3/1	Nurse Aide/ Licensed Staff
Activities	0	10		Nurse Aide
Grooming	0	3		Nurse Aide
Social Services	0	0		
	1	2	.5/.5/1	Nurse Aide/ Licensed Staff/ Social Worker
	2	3.6	.8/.8/2	Nurse Aide/ Licensed Staff/ Social Worker
~~Continence Restorative~~	~~0~~	~~0~~		
	~~1~~	~~14~~	~~12/2~~	~~Nurse Aide/ Licensed Staff~~

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
~~Continence~~	~~2~~	~~26~~	~~24/2~~	~~Nurse Aide/~~
~~Restorative~~	~~1~~	~~14~~	~~12/2~~	~~Nurse Aide/~~ ~~Licensed Staff~~
Restraint Management and Reduction	0	0		
	1	8	6/2	Nurse Aide/ Licensed Staff
Communication	0	0		
	1	2.5	2/.5	Nurse Aide/ Licensed Staff
	2	5	4/1	Nurse Aide/ Licensed Staff
	3	7.5	6/1.5	Nurse Aide/ Licensed Staff

Agency Note: level "0" carries no reimbursement potential when accompanied by "0" time. Level "0" provides reimbursement for every facility when accompanied with time. Such time becomes a facility's base rate for every resident.

d) The following reimbursement times, allocations, and need levels apply for all reimbursement periods commencing on or after July 1, 1991.

Item	Level	Time	Allocation	Staff Type
Bathing, Grooming	0	7	6/1	Nurse Aide/ Licensed Staff
	1	13	12/1	Nurse Aide/ Licensed Staff
	2	23	22/1	Nurse Aide/ Licensed Staff
Clothing	0	5	4/1	Nurse Aide/ Licensed Staff
	1	11	10/1	Nurse Aide/ Licensed Staff
	2	21	20/1	Nurse Aide/ Licensed Staff
Eating	0	7	6/1	Nurse Aide/ Licensed Staff

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
Eating	1	16	15/1	Nurse Aide/ Licensed Staff
	2	40	39/1	Nurse Aide/ Licensed Staff
	3	40		Licensed Staff
Mobility	0	6	5/1	Nurse Aide/ Licensed Staff
	1	13	12/1	Nurse Aide/ Licensed Staff
	2	15	14/1	Nurse Aide/ Licensed Staff
Continence	0	2		
	1	14		Nurse Aide
	2	19.6		Nurse Aide
Psycho-Social Care	0	12		Nurse Aide
	1	28	19.5/8.5	Nurse Aide/ Licensed Staff
Appliances	0	0		
	1	7	6/1	Nurse Aide/ Licensed Staff
Catheters	0	0		
	1	12.1	6/6.1	Nurse Aide/ Licensed Staff
Pressure Ulcer Care	0	0		
	1	8		Licensed Staff
	2	20		Licensed Staff
	3	0	0/0	
	4	0	0/0	
Pressure Ulcer Prevention	0	0		Nurse Aide/
	1	8	6/2	Licensed Staff
	2	14	12/2	Nurse Aide/ Licensed Staff
Wound Care	0	0		
	1	6		Licensed Staff
	2	18		Licensed Staff

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
Injections	0	0		
	1	1		Licensed Staff
	2	4.5		Licensed Staff
Intravenous. Clysis	0	0		
	1	4		Licensed Staff
	2	8		Licensed Staff
Lab Specimen	0	0		
	1	1	.5/.5	Nurse Aide/ Licensed Staff
	2	2	1/1	Nurse Aide/ Licensed Staff
	3	10	5/5	Nurse Aide/ Licensed Staff
Speech - Language Pathology and Audiology	0	0		
	1	0		Therapist
Medications and Medication Monitoring	0	12.8		Licensed Staff
	1	16.1		Licensed Staff
	2	18.1		Licensed Staff
Occupational Therapy	0	0		
	1	16	13/3	Nurse Aide/ Therapist
Ostomy Care	0			
	1	6		Licensed Staff
	2	13		Licensed Staff
Physical Therapy	0	0		
	1	16	13/3	Nurse Aide/ Therapist
Respiratory Therapy	0	0		
	1	17	15/2	Nurse Aide/ Licensed Staff
	2	25	5/20	Nurse Aide/ Licensed Staff

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
Tracheostomy Care	0	0		
	1	6		Licensed Staff
	2	13		Licensed Staff
Suctioning	0	0		
	1	5		Licensed Staff
	2	30		Licensed Staff
Passive Range of Motion	0	0		
	1	11.8		Nurse Aide
Resident Assessment	0	2.6	.5/1.1/ .7/.3	Nurse Aide/ Licensed Staff /Registered Nurse/Social Worker
	1	7.8	1.5/3.3/ 2.1/.9	Nurse Aide/ Licensed Staff /Registered Nurse/Social Worker
Discharge Planning	0	0		
	1	10		Licensed Staff
Health and Fitness	0	0		
	1	4	3/1	Nurse Aide/ Licensed Staff
Activities	0	10		Nurse Aide
Grooming	0	3		Nurse Aide
Social Services	0	0		
	1	2	.5/.5/1	Nurse Aide/ Licensed Staff /Social Worker
	2	7	1/1/5	Nurse Aide/ Licensed Staff /Social Worker

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE A Staff Time and Allocation by Need Level (Cont'd)

Item	Level	Time	Allocation	Staff Type
Restraint Management and Reduction	0	0		
	1	10	8/2	Nurse Aide/ Licensed Staff
Communication	0	0		
	1	2.5	2/.5	Nurse Aide/ Licensed Staff
	2	5	4/1	Nurse Aide/ Licensed Staff
	3	7/.5	6/1.5	Nurse Aide/ Licensed Staff

Agency Note: level "0" carries no reimbursement potential when accompanied by "0" time. Level "0" provides reimbursement for every facility when accompanied with time. Such time becomes a facility's base rate for every resident.

(Source: Amended at 16 Ill. Reg. 6479, effective March 20, 1992)

Section 147.TABLE B Staff Time and Allocation for Restorative Programs

Table B refers to Section 147.25(e), "Restorative Care"

a) The following reimbursement times, allocations, and need levels apply for all reimbursement periods commencing on January 1, 1988, through June 30, 1989.

Item	Level	Time	Allocation	Staff Type
Bathing, Grooming	0	0		
	1	14	12/2	Nurse Aide/ Licensed Staff
Clothing	0	0		
	1	14	12/2	Nurse Aide/ Licensed Staff
Eating	0	0		
	1	14	12/2	Nurse Aide/ Licensed Staff

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE B Staff Time and Allocation for Restorative Programs (Cont'd)

Item	Level	Time	Allocation	Staff Type
Mobility	0	0		
	1	20	18/2	Nurse Aide/ Licensed Staff

Agency Note: Level "0" carries no reimbursement potential when accompanied by "0" time.

b) The following reimbursement times, allocations, and need levels apply for all reimbursement periods commencing on ~~or after~~ July 1, 1989 through December 31, 1990.

Item	Level	Time	Allocation	Staff Type
Bathing, Grooming	0	0		
	1	14	12/2	Nurse Aide/ Licensed Staff
	2	20	18/2	Nurse Aide/ Licensed Staff
Clothing	0	0		
	1	14	12/2	Nurse Aide/ Licensed Staff
	2	20	18/2	Nurse Aide/ Licensed Staff
Eating	0	0		
	1	14	12/2	Nurse Aide/ Licensed Staff
	2	23	21/2	Nurse Aide/ Licensed Staff
Mobility	0	0		
	1	20	18/2	Nurse Aide/ Licensed Staff
	2	27	25/2	Nurse Aide/ Licensed Staff

Agency Note: Level "0" carries no reimbursement potential when accompanied by "0" time.

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE B Staff Time and Allocation for Restorative Programs (Cont'd)

c) The following reimbursement times, allocations, and need levels, apply for all reimbursement periods commencing on January 1, 1991 through June 30, 1991.

Item	Level	Time	Allocation	Staff Type
Bathing, Grooming	0	0		
	1	14	12/4	Nurse Aide/ Licensed Staff
	2	20	18/2	Nurse Aide/ Licensed Staff
Clothing	0	0		
	1	14	12/2	Nurse Aide/ Licensed Staff
	2	20	18/2	Nurse Aide/ Licensed Staff
Eating	0	0		
	1	14	12/2	Nurse Aide/ Licensed Staff
	2	23	21/2	Nurse Aide/ Licensed Staff
Mobility	0	0		
	1	20	18/2	Nurse Aide/ Licensed Staff
	2	27	25/2	Nurse Aide/ Licensed Staff
Continence	0	0		
	1	14	12/2	Nurse Aide/ Licensed Staff
	2	26	24/2	Nurse Aide/ Licensed Staff

Agency Note: Level "0" carries no reimbursement potential when accompanied by "0" time.

d) The following reimbursement times, allocations, and need levels apply for all reimbursement periods commencing on or after July 1, 1991.

Item	Level	Time	Allocation	Staff Type
Bathing, Grooming	0	0		

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

Section 147.TABLE B Staff Time and Allocation for Restorative Programs (Cont'd)

Item	Level	Time	Allocation	Staff Type
Bathing, Grooming	1	16	12/4	Nurse Aide/ Licensed Staff
	2	22	18/4	Nurse Aide/ Licensed Staff
Clothing	0	0		
	1	16	12/4	Nurse Aide/ Licensed Staff
	2	22	18/4	Nurse Aide/ Licensed Staff
Eating	0	0		
	1	27	22/5	Nurse Aide/ Licensed Staff
	2	36	31/5	Nurse Aide/ Licensed Staff
Mobility	0	0		
	1	22	18/4	Nurse Aide/ Licensed Staff
	2	29	25/4	Nurse Aide/ Licensed Staff
Continence	0	0		
	1	14	12/2	Nurse Aide/ Licensed Staff
	2	26	24/2	Nurse Aide/ Licensed Staff

(Source: Amended at 16 Ill. Reg. 6479, effective March 20, 1992)

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of April 1, 1992 through April 7, 1992, and have been scheduled for review by the Committee at its May 12, 1992 meeting. Other items not contained in this published list may also be considered by the Committee at its May meeting. Members of the public wishing to express their views with respect to a rule should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules, 509 South Sixth Street, Suite 500, Springfield, IL 62701.

Second Notice Expires	Agency and Rule	Start of First Notice	JCAR Meeting
5/12/92	State Board of Education, Preschool Educational and Coordinated Model Preschool Educational Programs (23 Ill Adm Code 235)	1/10/92 16 Ill. Reg. 439	5/12/92
5/12/92	Department of Conservation, Consignment of Licenses (17 Ill Adm Code 2520)	2/14/92 16 Ill Reg 2297	5/12/92
5/12/92	Department of Conservation, Designation of Restricted Waters in the State of Illinois (17 Ill Adm Code 2030)	2/14/92 16 Ill Reg 2302	5/12/92
5/18/92	Department of Transportation, Dixon Municipal Airport Hazard Zoning (92 Ill Adm Code 97)	12/13/91 15 Ill Reg 17907	5/12/92
5/18/92	Illinois Commerce Commission, Joint Rules of the ICC, OSFM and ESDA: Fire Protection and Emergency Services for Telecommunications Facilities (83 Ill Adm Code 785)	12/6/91 15 Ill Reg 17427	5/12/92
5/18/92	Office of the State Fire Marshal, Joint Rules of the ICC, OSFM and ESDA: Fire Protection and Emergency Services for Telecommunications Facilities (41 Ill Adm Code 102)	12/6/91 15 Ill Reg 17442	5/12/92
5/18/92	Emergency Services and Disaster Agency, Joint Rules of the ICC, OFSM and ESDA: Fire Protection and Emergency Services for Telecommunications Facilities (29 Ill Adm Code 700)	12/6/91 15 Ill Reg 17440	5/12/92

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED
(page 2)

Second Notice Expires	Agency and Rule	Start of First Notice	JCAR Meeting
5/18/92	Department of Central Management Services, Americans With Disabilities Act Grievance Procedure (4 Ill Adm Code 450)	2/14/92 16 Ill Reg 2292	5/12/92
5/20/92	Department of Mines and Minerals, Americans With Disabilities Act Grievance Procedure (2 Ill Adm Code 1052)	2/14/92 16 Ill Reg 2322	5/12/92
5/21/92	Department of Veterans' Affairs, Americans With Disabilities Act Grievance Procedure (95 Ill Adm Code 122)	2/7/92 16 Ill Reg 2113	5/12/92
5/21/92	Joint Committee on Administrative Rules, Expedited Corrections (1 Ill Adm Code 245)	2/14/92 16 Ill Reg 2314	5/12/92

PROCLAMATION

92-120
ALCOHOL AWARENESS MONTH
(Revised)

Whereas, one in four Illinoisans comes from a home in which one or more family members has an alcohol problem; and

Whereas, while it is illegal in Illinois for persons under age 21 to consume alcohol, 43 percent of students in grades 7-12 have used alcohol in the past month, and 65 percent have tried alcohol at least once; and

Whereas, Fetal Alcohol Syndrome is one of the top three known causes of birth defects and the only preventable cause among those three; and

Whereas, alcoholism and related problems cost Illinois industry billions in lost productivity, absenteeism, on-the-job accidents, and insurance claims; and

Whereas, more than half of criminal offenders convicted of violent crimes used alcohol just before the offense. Alcohol is often linked to suicides, domestic violence, accidents, and fires; and

Whereas, Lieutenant Governor Bob Kustra is coordinating Illinois' efforts to combat the abuse of alcohol and other drugs. The Illinois Drug Educaton Alliance, the Alliance Against Intoxicated Motorists, Mothers Against Drunk Drivers, the Illinois Alcoholism and Drug Dependence Association and the Illinois Department of Alcoholism and Substance Abuse will be sponsoring public awareness activities and programs during April in conjunction with the national observance of Alcohol Awareness Month;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 1992 a ALCOHOL AWARENESS MONTH in Illinois and urge all citizens to support efforts to curb the abuse of alcohol.

Issued by the Governor April 1, 1992.
Filed with the Secretary of State April 2, 1992.

92-143
AIDS AWARENESS WEEK

Whereas, AIDS is a devastating disease which affects millions of people nationwide; and

Whereas, over the past year, the Illinois Department of Public Health recorded 1,621 new AIDS cases, bringing the total number of cases in our state to 6,572--a 34 percent increase; and

Whereas, educating and informing the public about AIDS, its causes, and prevention is crucial to controlling the spread of the disease; and

Whereas, the Springfield Area AIDS Task Force has designated April 3-10, 1992, as AIDS Awareness Week; and

Whereas, the task force will sponsor several events during that week as part of a continuing effort to educate our citizens;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 3-10, 1992, as AIDS AWARENESS WEEK in Illinois.

Issued by the Governor March 18, 1992.
Filed with the Secretary of State April 2, 1992.

92-144
ASSYRIAN-AMERICAN DAY

Whereas, Illinois Assyrian-American citizens have built a reputation as industrious and trustworthy people; and

Whereas, they have contributed to the cultural heritage and economic progress of our state and our nation; and

Whereas, on April 1, 1992, Illinois' Assyrian-American citizens will celebrate their traditional New Year 6742 with a parade in downtown Chicago;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 1, 1992, as ASSYRIAN-AMERICAN DAY in Illinois.

Issued by the Governor March 25, 1992.
Filed with the Secretary of State April 2, 1992.

92-145
STAY IN SCHOOL--STAY OFF DRUGS--BE ALL YOU CAN BE YEAR

Whereas, Gallup Poll findings show that Americans believe drug use and lack of discipline are the greatest problems facing education today; and

Whereas, the National School Board Association states at least one million students drop out of school each year and another 20 million are potentially at risk of dropping out; and

Whereas, during the 1990-91 academic year, the U.S. Army Recruiting Battalion Milwaukee launched a "Stay In School-Stay Off Drugs" campaign targeted at students, educators, employers, and the media; and

Whereas, the U.S. Army Recruiting Battalion Milwaukee is continuing the campaign for the 1992-93 school year to encourage students to stay off drugs, stay in school, and be all they can be;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim the 1992-93 school year as STAY IN SCHOOL--STAY OFF DRUGS--BE ALL YOU CAN BE YEAR in Illinois.

Issued by the Governor March 25, 1992.
Filed with the Secretary of State April 2, 1992.

92-146
ARTS WEEK

Whereas, the arts in all forms are treasures that bring joy

to everyone; and

Whereas, our lives are enriched by the art that surrounds us in our everyday environments, the art that is part of our history, and the art of far-away places that we bring home in our hearts and minds; and

Whereas, the arts in Illinois deserve recognition and support so they may continue to flourish in abundant variety; and

Whereas, the Illinois Arts Council and the National Endowment for the Arts are two organizations that play a vital role in bringing the arts to our citizenry; and

Whereas, central to that partnership is the shared belief that freedom of artistic expression must remain unfettered by government interference in its content;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim September 21-27, 1992, as ARTS WEEK in Illinois.

Issued by the Governor March 26, 1992.

Filed with the Secretary of State April 2, 1992.

92-147
FRANCHISING WEEK

Whereas, sales of goods and services by franchised businesses will contribute more than $758.5 billion to the U.S. economy in 1992, accounting for more than one-third of all retail sales; and

Whereas, franchised businesses employ more than 7.2 million people in more than 60 different industries; and

Whereas, millions of people benefit from the high quality of goods and services provided by franchised businesses throughout the United States; and

Whereas, National Franchising Week is an annual national campaign to inform the public about franchising and the contributions it makes to our economy;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 5-12, 1992, as FRANCHISING WEEK in Illinois to foster a greater awareness of franchising and its economic benefits.

Issued by the Governor March 26, 1992.

Filed with the Secretary of State April 2, 1992.

92-148
LONG-TERM CARE ADMINISTRATORS WEEK

Whereas, Long-Term Care Administrators care for our loved ones and strive to provide their residents the opportunity to experience the highest quality of life; and

Whereas, Long-Term Care Administrators work long hours maintaining the quality of care given in their facilities and continuously striving to improve their facilities; and

Whereas, Long-Term Care Administrators are bound by numerous regulations and budgetary constraints, yet they succeed in

performing their duties while motivating their staff;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim March 23-29, 1992, as LONG-TERM CARE ADMINISTRATORS WEEK in Illinois, in recognition of our state's 1,683 licensed long-term care administrators.

Issued by the Governor March 26, 1992.

Filed with the Secretary of State April 2, 1992.

92-149
OCCUPATIONAL THERAPY MONTH

Whereas, occupational therapists and occupational therapy assistants work in our schools, rehabilitation centers, hospitals, and nursing homes to help our citizens with disabilities develop the functional skills they need to lead productive, satisfying lives; and

Whereas, occupational therapists are instrumental in improving the daily lives of infants with birth defects, children with learning disabilities, workers injured on the job, and families dealing with the problems of aging relatives; and

Whereas, 1992 marks the 75th anniversary of the American Occupational Therapy Association and the 73rd anniversary of the Illinois Occupational Therapy Association; and

Whereas, the Illinois Occupational Therapy Association has designated April 1992 as National Occupational Therapy Month to highlight the availability of occupational therapy services, as well as the rewards an occupational therapy career may provide;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 1992 as OCCUPATIONAL THERAPY MONTH in Illinois in recognition of the highly valued services occupational therapists provide to our citizens.

Issued by the Governor March 26, 1992.

Filed with the Secretary of State April 2, 1992.

92-150
AQUATIC SAFETY AWARENESS WEEK

Whereas, each year, more than 75,000,000 individuals participate in water-related activities; and

Whereas, about 7,000 of these individuals are victims of drownings annually, and numerous others are injured in accidents involving aquatic recreation; and

Whereas, during May 19-25, 1992, the Aquatic Council of the American Alliance of Health, Physical Education, Recreation and Dance (AAHPERD) is sponsoring National Aquatic Safety Awareness Week to promote the importance of water safety and prevent needless tragedies;

Therefore, I, Jim Edgar, proclaim May 19-25, 1992, as AQUATIC SAFETY AWARENESS WEEK in Illinois and urge citizens to boost their awareness of water safety and accident prevention.

Issued by the Governor March 30, 1992.
Filed with the Secretary of State April 2, 1992.

92-151
DINNER OF CHAMPIONS DAY

Whereas, multiple sclerosis (MS) is a neurological disease affecting the central nervous system, including the brain and the spinal cord; and

Whereas, MS is the number one disabling disease affecting young adults. Its victims are usually between the ages of 20 and 40; and

Whereas, the National Multiple Sclerosis Society, a voluntary health agency, was established in 1945 when a small group of patients and their families joined together to overcome this perplexing disease of the central nervous system; and

Whereas, since 1960, the Chicago-Northern Illinois Chapter of NMSS has been a leader in client services and dollars raised for research; and

Whereas, on April 30, 1992, Chicago area business and civic leaders will join the Chicago-Greater Illinois Chapter in hosting a "Dinner of Champions" to honor people and organizations who have shown outstanding humanitarian endeavors and dedication;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 30, 1992, as DINNER OF CHAMPIONS DAY in Illinois.

Issued by the Governor March 30, 1992.
Filed with the Secretary of State April 2, 1992.

92-152
MALCOLM X COLLEGE CAREER EXPO DAY

Whereas, Malcolm X College, one of the eight City Colleges of Chicago, serves a culturally rich and diverse community and is dedicated to the empowerment of all individuals; and

Whereas, Malcolm X College offers innovative and progressive programs in radiology, nursing, dietetic technology, nephrology/renal technology, medical laboratory technology, cardiopulmonary therapy, pharmacology, physician's assistant training, emergency medical technology/paramedic training, mortuary science/pathology assistant training, child development, teacher training, business, secretarial sciences, liberal arts, adult learning skills, and adult continuing education; and

Whereas, Malcolm X College's third annual Career Expo will be held Wednesday, April 8, and is expected to draw more than 2,000 students and community residents and more than 100 health facilities, corporations, government agencies, nonprofit organizations, and universities;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 8, 1992, as MALCOLM X COLLEGE CAREER EXPO DAY in Illinois.

Issued by the Governor March 30, 1992.
Filed with the Secretary of State April 2, 1992.

92-153
PARKLAND COLLEGE MADRIGALS RECOGNIZED

Whereas, 1992 marks the 500th anniversary of Christopher Columbus' discovery of America; and

Whereas, to commemorate the anniversary, the First American Music Encounters (FAME), the Washington, D.C. Columbus Celebration Association, the Council of the District of Columbia, and the National Festival of the States Association are presenting the "Musical Salute to the Discovery of America" in Washington, D.C., from March 15-July 15, 1992; and

Whereas, the celebration will feature outstanding orchestras, bands, choirs, and specialty dance groups selected from high school, college, community, and church organizations of each state; and

Whereas, the Parkland College Madrigals from Parkland College in Champaign have earned the honor of serving as one of Illinois' performing representatives for the "Musical Salute to the Discovery of America";

Therefore, I, Jim Edgar, Governor of the State of Illinois, give special recognition to the PARKLAND COLLEGE MADRIGALS for being selected to represent our state in the musical commemoration of the discovery of our country.

Issued by the Governor March 30, 1992.
Filed with the Secretary of State April 2, 1992.

92-154
VOLUNTEER WEEK

Whereas, our nation was built upon a spirit of volunteerism, and the talents and energies of American volunteers continue to be one of our greatest resources; and

Whereas, America cannot depend on government alone to solve all of its societal problems; and

Whereas, volunteerism is increasingly recognized as an important partner with government and industry in doing the work of the nation; and

Whereas, the active involvement of citizens in Illinois is needed today more than ever to combat growing human and social problems, to renew our belief that these problems can be solved, and to strengthen our sense of community; and

Whereas, volunteering offers all citizens - young and old - the opportunity to participate in the life of their community and lend their talents and resources to address some of the major issues facing our state; and

Whereas, it is fitting for all citizens to join in this celebration of our rich volunteer heritage and give special

recognition to the dedicated volunteers and volunteer programs that contribute immeasurably to communities throughout Illinois;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 26-May 2, 1992, as VOLUNTEER WEEK in Illinois.

Issued by the Governor March 30, 1992.

Filed with the Secretary of State April 2, 1992.

92-155
ARBOR AND BIRD DAY

"Our holidays repose upon the past; Arbor Day proposes for the future." -J. Sterling Morton

Whereas, in 1872, J. Sterling Morton proposed the first officially recognized Arbor Day in the United States. He also instilled his love of trees and hope for the future in his son, Joy, who founded the Morton Arboretum in Lisle, Illinois, and endowed our state with an internationally known botanical landmark; and

Whereas, the last Friday in April is generally observed as Arbor Day and will again be marked with statewide planting ceremonies by many citizens' groups. The 275 garden clubs affiliated with the Garden Club of Illinois will spearhead this observance; and

Whereas, state highway rights-of-way make the Illinois Department of Transportation the largest single landowner in the state. There is no better place to fight for tree resources and wildlife habitats, struggle against pollution, provide windbreaks, and stabilize watersheds than on land held in trusteeship for the people of Illinois;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 24, 1992, as ARBOR AND BIRD DAY in Illinois and encourage citizens to plant trees on this day.

Issued by the Governor April 1, 1992.

Filed with the Secretary of State April 2, 1992.

92-156
BREASTFEEDING PROMOTION MONTH

Whereas, during the month of May, the Illinois Department of Public Health, in coordination with Regional Breastfeeding Task Forces, public and private organizations, physicians, and hospitals throughout Illinois, is promoting the importance of breastfeeding; and

Whereas, this observance reminds Illinoisans that breastfeeding is nutritionally the best choice for infant feeding; and

Whereas, one of the Surgeon General's Health Promotion/Disease Prevention Objectives for the nation for the year 2000 is to increase the percentage of women who breastfeed

their babies; and

Whereas, the percentage of women in Illinois choosing to breastfeed their infants is below the national average and the Surgeon General's Breastfeeding Objective for the nation; and

Whereas, increased evidence links education, determination, and support to the success of breastfeeding;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim May 1992 as BREASTFEEDING PROMOTION MONTH in Illinois and urge our communities to offer breastfeeding education and support to assure parents the opportunity of making informed decisions about feeding their infants.

Issued by the Governor April 1, 1992.

Filed with the Secretary of State April 2, 1992.

92-157
CATHOLIC CHARITIES DAY

Whereas, Catholic Charities of the Archdiocese of Chicago has shown compassion to the unserved and underserved people of the Chicago area since 1917; and

Whereas, for 75 years, Catholic Charities of the Archdiocese of Chicago has served millions of people in our state, without regard to religious, national, racial, social, or economic backgrounds; and

Whereas, Catholic Charities of the Archdiocese of Chicago provides social services in Cook and Lake counties to benefit children, families, elderly people, and those lacking basic human needs; and

Whereas, Catholic Charities of the Archdiocese of Chicago's mission is to help people who have exhausted their own resources to assume or resume a responsible role in society;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim May 3, 1992, as CATHOLIC CHARITIES DAY in Illinois.

Issued by the Governor April 1, 1992.

Filed with the Secretary of State April 2, 1992.

92-158
HEALTHCARE SECURITY/SAFETY OFFICER WEEK/HEALTHCARE SECURITY/SAFETY OFFICER DAY

Whereas, security/safety professionals seek to provide a safe place for all, respecting the individuality, wholeness, integrity, dignity, and rights of all humanity; and

Whereas, the efforts of healthcare security/safety professionals have significantly reduced the losses to health care organizations, patients, and staff; and

Whereas, a tremendous need exists for well-trained healthcare security/safety personnel; and

Whereas, the International Association for Healthcare Security/Safety is promoting public recognition of these

professionals;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim October 4-10, 1992, as HEALTHCARE SECURITY/SAFETY OFFICE WEEK and October 7, 1992, as HEALTHCARE SECURITY/SAFETY OFFICER DAY in Illinois.

Issued by the Governor April 1, 1992.

Filed with the Secretary of State April 2, 1992.

92-159
NATIONAL PRESERVATION WEEK

Whereas, historic preservation gives Americans an authentic experience of their diverse heritage and provides direction for future generations; and

Whereas, historic preservation enhances the livability of cities, towns, and rural areas across our nation; and

Whereas, observing Preservation Week provides an opportunity for citizens of all ages and all cultures to maintain, preserve, and protect America's heritage; and

Whereas, the theme for Preservation Week 1992 is "Preservation Brings History to Life";

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim May 10-16, 1992, as NATIONAL PRESERVATION WEEK.

Issued by the Governor April 1, 1992.

Filed with the Secretary of State April 2, 1992.

92-160
ORGAN AND TISSUE DONOR AWARENESS WEEK

Whereas, in Illinois today, proven medical techniques make it possible to transplant kidneys, hearts, livers, bones, bone marrow, corneas, and skin; and

Whereas, many people already have been given the gifts of hearing and sight, freedom from dialysis, and a normal, healthy future thanks to organ transplants, but many more wait in vain because there aren't enough organ donors; and

Whereas, although the number of donors in Illinois was up last year, with 179 individuals giving 637 organs, the number of people on waiting lists for organ donations also rose by seven percent; and

Whereas, anyone, regardless of age or condition, can become an organ donor. In Illinois, a witnessed signature on the back of a driver's license or on a uniform donor card verifies donor status;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 19-25, 1992, as ORGAN AND TISSUE DONOR AWARENESS WEEK in Illinois, and I urge everyone to seriously consider becoming an organ donor at this time.

Issued by the Governor April 1, 1992.

Filed with the Secretary of State April 2, 1992.

92-161
RURAL ELECTRIC AND TELEPHONE YOUTH DAY

Whereas, for the 33rd year, the Electric Telephone Cooperatives of Illinois are sponsoring a paid tour of Washington, D.C., for approximately 70 outstanding Illinois high school students. These young leaders are selected on the basis of essay and youth leadership contests sponsored by member-cooperatives; and

Whereas, the Illinois students, along with about 1,500 contest winners from other states, will have an opportunity to witness their federal government in action during the "Youth to Washington" tour June 12-19, 1992; and

Whereas, in an effort to provide a broader educational experience for more students throughout the state, the Electric and Telephone Cooperatives of Illinois will also sponsor a trip to our state capital for approximately 175 finalists in the contest;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 29, 1992, as RURAL ELECTRIC AND TELEPHONE YOUTH DAY in Illinois and wish the participants a rewarding experience.

Issued by the Governor April 1, 1992.

Filed with the Secretary of State April 2, 1992.

92-162
WORLD HEALTH DAY

Whereas, the health of the citizens of our state is inseparably linked with the health of other Americans and people throughout the world; and

Whereas, more than 40,000 Illinoisans die each year from diseases of the heart and blood vessels; and

Whereas, cardiovascular disease is the leading cause of death in Illinois; and

Whereas, the Illinois Department of Public Health is continuing its commitment to the promotion of healthful lifestyles in an effort to reduce the incidence of cardiovascular disease; and

Whereas, the Illinois Department of Public Health conducts a variety of programs designed to make Illinoisans aware of the importance of proper nutrition, regular exercise, detection and control of hypertension, and abstinence from tobacco as vital factors in the prevention of cardiovascular disease; and

Whereas, the World Health Organization has established April 7 of each year as World Health Day--an occasion to educate, inform, and focus on the unity of the health concerns of the world; and

Whereas, the theme of World Health Day 1992 is "Heartbeat--the Rhythm of Health;"

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim April 7, 1992, as WORLD HEALTH DAY in Illinois and urge all Illinoisans to join their fellow citizens of the world in participating in activities to advance the prevention of cardiovascular disease.

Issued by the Governor April 1, 1992.

Filed with the Secretary of State April 2, 1992.

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JCAR - Joint Committee on Administrative Rules

ACTION CODES

A – Adopted Rule	*P – Proposed Rule*
AR – Adopted Repealer	*PF – Prohibited Filing Ordered by JCAR*
C – Notice of Corrections	*PP – Peremptory or Court ordered Rules*
CC – Codification Changes	*PR – Proposed Repealer*
E – Emergency Rule	*R – Refusal to meet JCAR objection*
ER – Emergency Repealer	*RC – Statement of Recommendation*
M – Modification to meet JCAR objections	*S – Suspension ordered by JCAR*
O – JCAR Statement of Objections	*W – Withdrawal to meet JCAR objections*

EXAMPLE:

AGRICULTURE, DEPARTMENT OF
8 Ill. Adm. Code 285 Ill. Grain Insurance Act (P-18048/85; A-6818)

TITLE — PART — ACTION CODE — PAGE NUMBER — PAGE NUMBER — ACTION CODE — PREVIOUS VOLUME

ALL RULES ARE LISTED BY PART NUMBER AND HEADING ONLY. (FOR ACTION ON SPECIFIC SECTIONS, PLEASE REFER TO THE SECTIONS AFFECTED INDEX.) IF THERE ARE ANY QUESTIONS, PLEASE CONTACT THE ADMINISTRATIVE CODE DIVISION AT (217) 782-9786.

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62 Ill. Adm. Code 2501	Abandoned Mined Lands Reclamation (P-2719) (E-2897)

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89 Ill. Adm. Code 240	Community Care Program (E-17398/91; S-1744, W-2955; M-2943) (P-17007/91; PF-1744; M-2930) (E-2630) (E-2901) (E-4069) (P-4087; C-5083)
89 Ill. Adm. Code 230	Older Americans Act Programs (P-3605)

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4 Ill. Adm. Code 550	Americans With Disabilities Act Grievance Procedure (P-5097)
8 Ill. Adm. Code 30	Animal Control Act(P-3618)
8 Ill. Adm. Code 110	Animal Diagnostic Laboratory Act (P-3624)
8 Ill. Adm. Code 85	Diseased Animals (P-3635)
8 Ill. Adm. Code 55	Hatcheries, Poultry Flocks, & Produce Thereof (P-3646)
8 Ill. Adm. Code 90	Ill. Dead Animal Disposal Act (P-3653)
8 Ill. Adm. Code 115	Ill. Pseudorabies Control Act (P-3661)
8 Ill. Adm. Code 40	Livestock Auction Markets (P-3673)
8 Ill. Adm. Code 125	Meat & Poultry Inspection Act (PP-1899) (P-1921)
2 Ill. Adm. Code 700	Organizational Chart, Description, Rulemaking Procedure, & Programs (A-3893)
8 Ill. Adm. Code 235	Seed Arbitration (P-2969)
8 Ill. Adm. Code 5	Standardization of Agriculture Products (P-3231)
8 Ill. Adm. Code 105	Swine Disease Control & Eradication Act (P-3680)

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4 Ill. Adm. Code 500	Americans With Disabilities Act Grievance Procedure (P-2721)
77 Ill. Adm. Code 2031	Award Criteria & Procedure (P-9149/91; AR-2455)
77 Ill. Adm. Code 2030	Award & Monitoring of Funds (P-9083/91; A-2457)
77 Ill. Adm. Code 2056	Driving Under the Influence Programs (P-4567)
77 Ill. Adm. Code 2030	Fiscal & Programmatic Requirements (P-9153/91; AR-2530)
77 Ill. Adm. Code 2090	Subacute Alcoholism & Substance Abuse Treatment Services (P-5104)
77 Ill. Adm. Code 2032	Suspension & Termination of Financial Assistance (P-9218; AR-2532)

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4 Ill. Adm. Code 125	Americans With Disabilities Act Grievance Procedures (P-2283)

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38 Ill. Adm. Code 307	Acquisition of Former Main Banking Premises or Branches of Eligible Depository Institutions (P-5391)
38 Ill. Adm. Code 354	Administration of Assets Obtained in Collection of a Debt (P-5395)
4 Ill. Adm. Code 375	Americans With Disabilities Act Grievance Procedures (P-4125)

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71 Ill. Adm. Code 110	Americans With Disabilities Act Grievance Procedure (P-3689)
44 Ill. Adm. Code 950	Prequalification & Suspension of Contractors (P-3695)

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56 Ill. Adm. Code 6000	Carnival & Amusement Ride Inspection Law (P-5399)

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4 Ill. Adm. Code 450	Americans With Disabilities Act Grievance Procedures (P-2292)
80 Ill. Adm. Code 303	Conditions of Employment (P-327)
89 Ill. Adm. Code 1300	Day Care (P-5141/91; A-4819)
80 Ill. Adm. Code 304	General Provisions (P-334)
80 Ill. Adm. Code 302	Merit & Fitness (P-336)
80 Ill. Adm. Code 310	Pay Plan (P-342) (E-711) (P-12051/91; A-3450) (PP-5068)
44 Ill. Adm. Code 5030	Personal Use of State Telephones (P-18013/91; A-4826)
80 Ill. Adm. Code 2650	Solicitation for Charitable Payroll Deductions (P-3235)
80 Ill. Adm. Code 2800	Travel (P-15199/91; A-4831)

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89 Ill. Adm. Code 305	Client Service Planning (P-5403)
89 Ill. Adm. Code 352	Financial Responsibility of Parents or Guardians of the Estates of Children (P-13229/91; A-3924)
89 Ill. Adm. Code 406	Licensing Standards for Day Care Homes (E-14734/91; M-2269)

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56 Ill. Adm. Code 2625	Economic Dislocation & Worker Adjustment Assistance (P-5124)
56 Ill. Adm. Code 2620	Employment & Training Assistance for Dislocated Workers (PR-12964/91; AR-6175)
14 Ill. Adm. Code 520	Enterprise Zone Program (P-9787/91; A-89)
47 Ill. Adm. Code 140	Ill. Clean & Beautiful Program (PR-13241/91; AR-2120)
14 Ill. Adm. Code 550	Local Tourism & Convention Bureau Program (P-10249/91; A-3464)
47 Ill. Adm. Code 100	Low Income Home Energy Assistance Program (P-14337/91; A-3940)
47 Ill. Adm. Code 120	State Administration of the Federal Community Services Block Grant Program (P-13993/91; A-3078)
56 Ill. Adm. Code 2630	Uniform Fiscal & Administrative Standards for the Job Training Partnership Act (P-8081/91; A-1524)

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92 Ill. Adm. Code 1311	Commodity Group Definitions (P-4195/91; W-2942)
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83 Ill. Adm. Code 770	Operator Service Providers (P-3242)
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83 Ill. Adm. Code 200	Rules of Practice (P-1936)
83 Ill. Adm. Code 410	Standards of Service for Electric Utilities (P-11899/91; A-2544)
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17 Ill. Adm. Code 830	Commercial Fishing & Musseling in Certain Waters of the State (P-18327/91; A-5257)
17 Ill. Adm. Code 860	Commercial Fishing in Lake Michigan (P-4616)
17 Ill. Adm. Code 115	Competitive Tournament Fishing on State Owned and/or Leased Water Areas (P-18045/91; A-4835)
17 Ill. Adm. Code 2520	Consignment of Licenses (P-2297)
17 Ill. Adm. Code 2030	Designation of Restricted Waters in the State of Illinois (P-2302)
17 Ill. Adm. Code 950	Dog Training on Department-Owned or -Managed Sites (P-5429)
17 Ill. Adm. Code 960	Dog Training on Non-Department Owned or -Managed Lands (P-5433)
17 Ill. Adm. Code 730	Dove Hunting (P-5143)
17 Ill. Adm. Code 590	Duck, Goose & Coot Hunting (P-14157/91; A-570)
17 Ill. Adm. Code 1590	Falconry & the Captive Propagation of Raptors (P-4132)
17 Ill. Adm. Code 890	Fish Removal With Chemicals (P-17811/91; A-5262)
17 Ill. Adm. Code 1530	Forest Products Transportation Act, The (P-2972)
17 Ill. Adm. Coode 510	General Hunting & Trapping on Department-Owned or -Managed Sites (P-5436)
17 Ill. Adm. Code 1010	Ill. List of Endangered & Threatened Fauna (P-13594/91; A-103)
17 Ill. Adm. Code 3010	Ill. Snowmobile Grant Program (P-14794/91; A-1806)
17 Ill. Adm. Code 3030	Land & Water Conservation Fund Grant Program (P-14807/91; A-1816)
17 Ill. Adm. Code 570	Muskrat, Mink , Raccoon, Opossu, Striped Skunk, Weasel, Red Fox, Gray Fox, Coyote, Beaver & Woodchuck (Groundhog) Trapping (P-5443)
17 Ill. Adm. Code 525	Nuisance Wildlife Control Permits (P-15647/91; A-1826)
17 Ill. Adm. Code 970	Pigeon Shooting Permits (PR-2727)
17 Ill. Adm. Code 550	Raccoon, Opossum, Striped Skunk, Red Fox, Gray Fox, Coyote & Woodchuck (Groundhog) Hunting (P-5454)
17 Ill. Adm. Code 150	Regulations for the Letting of Concessions, Farm Leases, Sale of Buildings and Facilities and Demolitions (P-18055/91; A-4839)
17 Ill. Adm. Code 3020	Snowmobile Trail Establishment Fund Grant Program (P-14820/91; A-1833)
17 Ill. Adm. Code 810	Sport Fishing Regulations for the Waters of Ill. (P-17817/91; A-5267) (E-6016)
17 Ill. Adm. Code 690	Squirrel Hunting (P-5157)
17 Ill. Adm. Code 880	Taking of Reptiles & Amphibians, The (P-13603/91; A-109)
17 Ill. Adm. Code 720	Taking of Wild Turkeys-Fall Archery Season, The (P-5466)
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17 Ill. Adm. Code 650	White-Tailed Deer Hunting by Use of Firearms (P-5501)
17 Ill. Adm. Code 660	White-Tailed Deer Hunting Season by Use of Muzzleloading Rifles (P-5525)
17 Ill. Adm. Code 740	Woodcock, Snipe Rail & Teal Hunting (P-5540)

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20 Ill. Adm. Code 405	School District #428 (P-5176)
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The Sections Affected Index lists, by Title, each Section of a codified Part on which rulemaking activity has occurred in this volume of the Register and is divided into two parts: the first lists the Sections on which rulemaking occurred in the previous issues of this volume year; the second lists the Sections on which rulemaking activity occurred in this issue of the Register. (The headings at the top of each page indicate the two parts: the first part shows the previous issue numbers inclusively and the date of the last published issue; the second lists the current issue number and date.) The columns in both parts indicate the type of rulemaking activity and the action taken along with the page number on which the first page of the notice of rulemaking activity appeared. If a Section on which action is being taken in the current volume (calendar year) of the Register was proposed in a previous volume, the last two digits of the previous volume's year appear immediately after the page number separated by a slash. (e.g. 1 Ill. Adm. Code 100.280 was proposed last year and adopted this year. The action entry reads: (P-8577/89; A-724) The codes for both columns are listed below. For a complete listing of the Titles of the *Illinois Administrative Code*, please refer to 1 Ill. Adm. Code 100.140 or contact the Administrative Code Division.

TYPE OF RULEMAKING		ACTION CODES	
am = amendment to existing Section	A = Adopted rule	O = JCAR Objection	
cc = codification changes	C = Correction	P = Proposed rule	
n = new Section	CC = Codification Changes	PF = Prohibited Filing	
r = repeal of existing Section	E = Emergency rule	PP = Peremptory rule	
rc = recodified	F = Failure to Remedy Objections	R = Refusal to Modify or Withdraw	
# = renumbered		RC = JCAR Recommendation	
	M = Modification	S = Suspended rule	
		W = Withdrawal of Proposed rule	

TITLE 1

245.100	n	(P-2314)
245.110	n	(P-2314)
245.120	n	(P-2314)
245.130	n	(P-2314)
245.140	n	(P-2314)
245.Ex. A	n	(P-2314)
245.Ex. B	n	(P-2314)

TITLE 2

700.10	am	(A-3893)
700.20	am	(A-3893)
700.30	am	(A-3893)
700.35	n	(A-3893)
700.40	am	(A-3893)
700.50	am	(A-3893)
700.60	am	(A-3893)
700.70	am	(A-3893)
700.100	am	(A-3893)
700.130	am	(A-3893)
700.140	am	(A-3893)
1052.10	n	(P-2322)
1052.20	n	(P-2322)
1052.30	n	(P-2322)
1052.40	n	(P-2322)
1052.50	n	(P-2322)
1052.60	n	(P-2322)
1052.70	n	(P-2322)
1052.80	n	(P-2322)
1052.Ap. A	n	(P-2322)
1720.100	n	(A-4503)
1720.110	n	(A-4503)
1720.120	n	(A-4503)
1720.200	n	(A-4503)
1720.210	n	(A-4503)
1720.300	n	(A-4503)
1720.310	n	(A-4503)
1720.320	n	(A-4503)
1720.330	n	(A-4503)
1720.340	n	(A-4503)
1720.350	n	(A-4503)
1720.360	n	(A-4503)
1720.370	n	(A-4503)
1720.380	n	(A-4503)
1800.10	am	(P-5565)
1800.20	am	(P-5565)
1800.100	am	(P-5565)
1800.Il. A	am	(P-5565)

TITLE 4

100.10	n	(P-3444)
100.20	n	(P-3444)
100.30	n	(P-3444)
100.40	n	(P-3444)
100.50	n	(P-3444)
100.60	n	(P-3444)
100.70	n	(P-3444)
125.10	n	(P-2283)
125.20	n	(P-2283)
125.30	n	(P-2283)
125.40	n	(P-2283)
125.50	n	(P-2283)
125.60	n	(P-2283)
125.70	n	(P-2283)
125.80	n	(P-2283)
125.Ap. A	n	(P-2283)
300.10	n	(P-3433)
300.20	n	(P-3433)
300.30	n	(P-3433)
300.40	n	(P-3433)
300.50	n	(P-3433)
300.60	n	(P-3433)
300.70	n	(P-3433)
350.110	n	(P-2106)
350.120	n	(P-2106)
350.130	n	(P-2106)
350.140	n	(P-2106)
350.150	n	(P-2106)
350.160	n	(P-2106)
350.170	n	(P-2106)
350.180	n	(P-2106)
375.10	n	(P-4125)
375.20	n	(P-4125)
375.30	n	(P-4125)
375.40	n	(P-4125)
375.50	n	(P-4125)
375.60	n	(P-4125)
375.70	n	(P-4125)
400.10	n	(P-5133)
400.20	n	(P-5133)
400.30	n	(P-5133)
400.40	n	(P-5133)
400.50	n	(P-5133)
400.60	n	(P-5133)
400.70	n	(P-5133)
450.10	n	(P-2292)
450.20	n	(P-2292)
450.30	n	(P-2292)
450.40	n	(P-2292)
450.50	n	(P-2292)
450.60	n	(P-2292)
450.70	n	(P-2292)
475.10	n	(P-3707)
475.15	n	(P-3707)
475.17	n	(P-3707)
475.20	n	(P-3707)
475.30	n	(P-3707)
475.40	n	(P-3707)
475.50	n	(P-3707)
500.1	n	(P-2721)
500.2	n	(P-2721)
500.3	n	(P-2721)
500.4	n	(P-2721)
500.5	n	(P-2721)
500.6	n	(P-2721)
500.7	n	(P-2721)
550.10	n	(P-5097)
550.20	n	(P-5097)
550.30	n	(P-5097)
550.40	n	(P-5097)
550.50	n	(P-5097)
550.60	n	(P-5097)
550.70	n	(P-5097)
600.10	n	(P-5569)
600.20	n	(P-5569)
600.30	n	(P-5569)

TITLE 4 (CONT'D)

600.40	n	(P-5569)
600.50	n	(P-5569)
600.60	n	(P-5569)
600.70	n	(P-5569)
650.10	n	(P-3253)
650.20	n	(P-3253)
650.30	n	(P-3253)
650.40	n	(P-3253)
650.50	n	(P-3253)
650.60	n	(P-3253)
650.70	n	(P-3253)

TITLE 8

5.90	r	(P-3231)
30.150	am	(P-3618)
40.5	am	(P-3673)
40.60	am	(P-3673)
40.100	am	(P-3673)
40.170	am	(P-3673)
55.10	am	(P-3646)
55.40	am	(P-3646)
55.45	am	(P-3646)
55.50	am	(P-3646)
55.90	am	(P-3646)
55.100	am	(P-3646)
85.5	am	(P-3635)
85.10	am	(P-3635)
85.15	am	(P-3635)
85.75	am	(P-3635)
85.80	am	(P-3635)
85.100	am	(P-3635)
85.115	am	(P-3635)
85.120	n	(P-3635)
90.5	n	(P-3653)
90.110	am	(P-3653)
105.5	am	(P-3680)
105.10	am	(P-3680)
105.30	am	(P-3680)
105.90	n	(P-3680)
110.50	am	(P-3624)
110.80	am	(P-3624)
110.90	am	(P-3624)
110.110	am	(P-3624)
110.120	am	(P-3624)
115.10	am	(P-3661)
115.20	am	(P-3661)
115.30	am	(P-3661)
115.50	am	(P-3661)
115.70	am	(P-3661)
115.80	am	(P-3661)
115.100	am	(P-3661)
125.10	am	(P-1921)
125.190	am	(P-1921)
125.260	am	(PP-1899) (P-1921)
125.270	am	(P-1921)
125.290	am	(P-1921)
125.295	n	(P-1921)
125.380	am	(PP-1899)
125.390	am	(P-1921)
235.10	n	(P-2969)
235.20	n	(P-2969)

TITLE 11

405.90	am	(P-2436)
415.60	n	(P-1263)
436.05	n	(P-15655/91; A-4520)
436.10	r	(P-15655/91; A-4520)
436.20	am	(P-15655/91; A-4520)
436.30	r	(P-15655/91; A-4520)
436.40	r	(P-15655/91; A-4520)
436.50	r	(P-15655/91; A-4520)
436.60	am	(P-15655/91; A-4520)
436.70	am	(P-15655/91; A-4520)
436.80	r	(P-15655/91; A-4520)
436.90	r	(P-15655/91; A-4520)
436.100	am	(P-15655/91; A-4520)
436.110	am	(P-15655/91; A-4520)
436.120	r	(P-15655/91; A-4520)
436.130	am	(P-15655/91; A-4520)
436.140	r	(P-15655/91; A-4520)
450.10	n	(P-2292)
1305.120	r	(P-2439)
1305.130	r	(P-2439)
1305.140	am	(P-2439)
1314.10	r	(P-2433)
1424.100	r	(P-2444)
1424.170	am	(P-2444)
1424.105	r	(P-2444)
1424.250	am	(P-1266)
1705.10	n	(P-1779)
1705.20	n	(P-1779)
1705.30	n	(P-1779)
1705.40	n	(P-1779)
1705.50	n	(P-1779)
1705.60	n	(P-1779)
1705.70	n	(P-1779)

TITLE 14

130.110	am	(P-14209/91; A-6000)
170.10	am	(P-5247)
170.11	am	(P-5247)
170.12	am	(P-5247)
170.13	am	(P-5247)
170.14	am	(P-5247)
170.17	am	(P-5247)
170.20	am	(P-5247)
170.30	n	(P-5247)
175.10	am	(P-7518/91; A-4058)
520.900	am	(P-89)
520.930	am	(P-89)
520.1100	n	(P-89)
520.1110	n	(P-89)
520.1120	n	(P-89)
520.1130	n	(P-89)
520.1140	n	(P-89)
550.35	am	(P-10249/91; A-3464)

TITLE 17

115.10	am	(P-18045/91; A-4835)
115.30	am	(P-18045/91; A-4835)
115.40	am	(P-18045/91; A-4835)
115.50	am	(P-18045/91; A-4835)
150.10	am	(P-18055/91; A-4839)
150.20	am	(P-18055/91; A-4839)
150.30	am	(P-18055/91; A-4839)

TITLE 17 (CONT'D)

150.40	am	(P-18055/91; A-4839)
510.10	am	(P-5436)
525.30	am	(P-15647/91; A-1826)
550.20	am	(P-5454)
550.30	am	(P-5454)
570.20	am	(P-5443)
570.30	am	(P-5443)
570.40	am	(P-5443)
590.10	am	(P-14157/91; A-570)
590.20	am	(P-14157/91; A-570)
590.60	am	(P-14157/91; A-570)
650.10	am	(P-5501)
650.20	am	(P-5501)
650.21	am	(P-5501)
650.22	am	(P-5501)
650.23	am	(P-5501)
650.40	am	(P-5501)
650.50	am	(P-5501)
650.60	am	(P-5501)
660.10	am	(P-5525)
660.20	am	(P-5525)
660.21	am	(P-5525)
660.25	am	(P-5525)
660.30	am	(P-5525)
660.40	am	(P-5525)
660.45	am	(P-5525)
660.50	am	(P-5525)
660.60	am	(P-5525)
670.10	am	(P-5482)
670.20	am	(P-5482)
670.30	am	(P-5482)
670.40	am	(P-5482)
670.50	am	(P-5482)
670.60	am	(P-5482)
690.20	am	(P-5157)
690.30	am	(P-5157)
710.10	am	(P-14833/91; A-1843)
710.20	am	(P-14833/91; A-1843)
710.21	n	(P-14833/91; A-1843)
710.30	am	(P-14833/91; A-1843)
710.50	am	(P-14833/91; A-1843)
715.10	am	(P-5475)
715.20	am	(P-5475)
715.40	am	(P-5475)
720.10	am	(P-5466)
720.20	am	(P-5466)
720.30	am	(P-5466)
720.40	am	(P-5466)
730.20	am	(P-5143)
730.30	am	(P-5143)
740.10	am	(P-5540)
740.20	am	(P-5540)
810.35	am	(P-17817/91; A-5267)
810.37	am	(P-17817/91; A-5267)
810.45	am	(P-17817/91; A-5267) (E-6016)
810.60	am	(P-17817/91; A-5267)
810.70	am	(P-17817/91; A-5267)
810.90	am	(P-17817/91; A-5267)
830.60	am	(P-18327/91; A-5257)
830.70	am	(P-18327/91; A-5257)
830.90	am	(P-18327/91; A-5257)
850.10	am	(P-4616)
850.20	am	(P-4616)
850.30	am	(P-4616)
880.10	n	(P-13603/91; A-109)
880.20	n	(P-13603/91; A-109)
880.30	n	(P-13603/91; A-109)
880.40	n	(P-13603/91; A-109)
880.50	n	(P-13603/91; A-109)
890.10	n	(P-17811/91; A-5262)
890.20	n	(P-17811/91; A-5262)
890.30	n	(P-17811/91; A-5262)
890.40	n	(P-17811/91; A-5262)
890.50	n	(P-17811/91; A-5262)
950.20	am	(P-5429)
950.40	am	(P-5429)
960.30	am	(P-5433)
970.10	r	(P-2727)
970.20	r	(P-2727)
970.30	r	(P-2727)
970.40	r	(P-2727)
970.50	r	(P-2727)
970.60	r	(P-2727)
1010.30	am	(P-13594/91; A-103)
1530.30	am	(P-2972)
1530.50	am	(P-2972)
1530.60	am	(P-2972)
1530.Ex. A	n	(P-2972)
1530.Ex. B	n	(P-2972)
1535.1	n	(P-2979)
1535.5	am	(P-2979)
1535.50	am	(P-2979)
1538.5	n	(P-775;W-4555) (P-4148)
1538.10	n	(P-775;W-4555) (P-4148)
1538.20	n	(P-775;W-4555) (P-4148)
1538.30	n	(P-775;W-4555) (P-4148)
1538.40	n	(P-775;W-4555) (P-4148)
1538.50	n	(P-775;W-4555) (P-4148)
1538.60	n	(P-775;W-4555) (P-4148)
1538.70	n	(P-775;W-4555) (P-4148)
1538.80	n	(P-775;W-4555) (P-4148)
1590.50	am	(P-4132)
1590.60	am	(P-4132)
1590.70	am	(P-4132)
1590.80	am	(P-4132)
1590.90	am	(P-4132)
1590.100	am	(P-4132)
1590.110	am	(P-4132)
1590.120	am	(P-4132)
2030.15	am	(P-2302)
2030.20	am	(P-2302)
2520.50	am	(P-2297)
3010.40	am	(P-14794/91; A-1806)
3010.50	am	(P-14794/91; A-1806)
3010.70	am	(P-14794/91; A-1806)
3010.80	am	(P-14794/91; A-1806)
3020.20	am	(P-14820/91; A-1833)
3020.40	am	(P-14820/91; A-1833)
3020.50	am	(P-14820/91; A-1833)
3020.70	am	(P-14820/91; A-1833)
3020.80	am	(P-14820/91; A-1833)
3030.30	am	(P-14807/91; A-1816)
3030.50	am	(P-14807/91; A-1816)
3030.60	am	(P-14807/91; A-1816)

TITLE 17 (CONT'D)

3035.40	am	(P-14783/91; A-1797)
3035.70	am	(P-14783/91; A-1797)
3035.80	am	(P-14783/91; A-1797)
4170.100	n	(P-5576)
4170.110	n	(P-5576)
4170.120	n	(P-5576)
4170.130	n	(P-5576)
4170.200	n	(P-5576)
4170.250	n	(P-5576)
4170.300	n	(P-5576)
4170.400	n	(P-5576)
4170.500	n	(P-5576)
4170.550	n	(P-5576)
4170.600	n	(P-5576)
4170.700	n	(P-5576)
4170.800	n	(P-5576)

TITLE 20

405.20	am	(P-5176)
405.50	am	(P-5176)
405.60	am	(P-5176)
435.10	am	(P-1941)
435.12	n	(P-1941)
435.15	am	(P-1941)
435.20	am	(P-1941)
435.30	am	(P-1941)
435.40	am	(P-1941)
435.50	am	(P-1941)
435.60	am	(P-1941)
435.70	n	(P-1941)
504.802	am	(P-3715)
504.810	am	(P-3715)
504.830	am	(P-3715)
504.905	am	(P-3715)
504.910	am	(P-3715)
504.920	am	(P-3715)
504.930	am	(P-3715)
525.110	am	(E-3583) (P-5166)
525.130	am	(P-5166)
525.140	am	(E-3583) (P-5166)
525.150	am	(P-5166)
1205.10	n	(P-4803)
1205.20	n	(P-4803)
1205.30	n	(P-4803)
1205.40	n	(P-4803)
1205.50	n	(P-4803)
1235.10	n	(E-17785/91; O-1746)
1235.20	n	(E-17785/91; O-1746)
1235.30	n	(E-17785/91; O-1746)
1235.40	n	(E-17785/91; O-1746)
1235.50	n	(E-17785/91; O-1746)
1235.60	n	(E-17785/91; O-1746)
1235.70	n	(E-17785/91; O-1746)
1235.80	n	(E-17785/91; O-1746)
1235.90	n	(E-17785/91; O-1746)
1235.100	n	(E-17785/91; O-1746)
1235.110	n	(E-17785/91; O-1746)
1235.120	n	(E-17785/91; O-1746)
1235.130	n	(E-17785/91; O-1746)
1285.10	n	(P-3840)
1285.20	n	(P-3840)
1285.30	n	(P-3840)
1285.40	n	(P-3840)
1285.50	n	(P-3840)
1285.60	n	(P-3840)
1285.70	n	(P-3840)
1285.80	n	(P-3840)
1570.10	n	(P-2732)
1570.20	n	(P-2732)
1570.30	n	(P-2732)
1570.40	n	(P-2732)
1570.50	n	(P-2732)
1570.60	n	(P-2732)
1580.10	n	(P-1948)
1580.20	n	(P-1948)
1580.30	n	(P-1948)
1580.40	n	(P-1948)
1580.50	n	(P-1948)
1720.15	am	(P-15251/91; A-4002)
1720.35	n	(E-727)
1800.10	n	(P-10)
1800.20	n	(P-10)
1800.30	n	(P-10)
1800.40	n	(P-10)
1810.100	n	(P-469) (E-732)
1810.110	n	(P-469) (E-732)
1810.200	n	(P-469) (E-732)
1810.210	n	(P-469) (E-732)
1810.220	n	(P-469) (E-732)
1810.230	n	(P-469) (E-732)
1810.240	n	(P-469) (E-732)
1810.250	n	(P-469) (E-732)
1810.300	n	(P-469) (E-732)
1810.400	n	(P-469) (E-732)
1810.410	n	(P-469) (E-732)
1810.420	n	(P-469) (E-732)
1810.430	n	(P-469) (E-732)
1810.440	n	(P-469) (E-732)
1810.500	n	(P-469) (E-732)
1810.510	n	(P-469) (E-732)
1810.520	n	(P-469) (E-732)
1810.530	n	(P-469) (E-732)
1810.540	n	(P-469) (E-732)
1810.550	n	(P-469) (E-732)
1810.600	n	(P-469) (E-732)
1810.610	n	(P-469) (E-732)
1810.620	n	(P-469) (E-732)
1810.700	n	(P-469) (E-732)
1810.710	n	(P-469) (E-732)
1810.720	n	(P-469) (E-732)
1810.730	n	(P-469) (E-732)
1810.800	n	(P-469) (E-732)
1810.900	n	(P-469) (E-732)
1810.910	n	(P-469) (E-732)
1810.1000	n	(P-469) (E-732)
1810.1010	n	(P-469) (E-732)
1810.1020	n	(P-469) (E-732)
1810.1100	n	(P-469) (E-732)
1810.1110	n	(P-469) (E-732)

TITLE 23

120.10	am	(P-1452)
120.30	am	(P-1452)
120.40	am	(P-1452)
120.50	am	(P-1452)

TITLE 23 (CONT'D)

120.60	am	(P-1452)
120.90	am	(P-1452)
130.10	am	(P-1439)
130.20	am	(P-1439)
130.30	am	(P-1439)
130.40	am	(P-1439)
130.45	n	(P-1439)
130.50	am	(P-1439)
226.605	am	(P-3724)
226.640	am	(P-3724)
235.10	n	(P-439)
235.20	n	(P-439)
235.30	n	(P-439)
235.40	n	(P-439)
235.45	n	(P-439)
235.50	n	(P-439)
235.60	n	(P-439)
235.100	n	(P-439)
235.110	n	(P-439)
235.120	n	(P-439)
235.130	n	(P-439)
235.135	n	(P-439)
235.140	n	(P-439)
235.150	n	(P-439)
260.40	am	(P-5550)
1015.10	n	(P-14852/91; A-4496)
1015.20	n	(P-14852/91; A-4496)
1015.30	n	(P-14852/91; A-4496)
1015.40	n	(P-14852/91; A-4496)
1015.50	n	(P-14852/91; A-4496)
1015.60	n	(P-14852/91; A-4496)
1015.70	n	(P-14852/91; A-4496)
2700.10	am	(P-4368)
2700.20	am	(P-4368)
2700.30	am	(P-4368)
2700.40	am	(P-4368)
2700.50	am	(P-4368)
2700.55	am	(P-4368)
2700.60	am	(P-4368)
2700.70	am	(P-4368)
2720.5	am	(P-4386)
2720.6	am	(P-4386)
2720.10	am	(P-15026/91;A-4060) (P-4386)
2720.20	am	(P-4386)
2720.25	am	(P-4386)
2720.30	am	(P-4386)
2720.40	am	(P-15026/91; A-4060) (P-4386)
2720.50	am	(P-4386)
2720.55	am	(P-4386)
2720.60	am	(P-4386)
2720.70	am	(P-4386)
2720.80	am	(P-4386)
2720.90	am	(P-4386)
2720.105	am	(P-4386)
2720.120	am	(P-4386)
2720.130	am	(P-4386)
2720.200	am	(P-4386)
2720.210	am	(P-4386)
2720.Ap. A	am	(P-4386)
2730.5	am	(P-4416)
2730.10	am	(P-4416)
2730.20	am	(P-4416)
2733.10	am	(P-4423)
2733.20	am	(P-4423)
2733.30	am	(P-4423)
2735.10	am	(P-4458)
2735.20	am	(P-4458)
2735.30	am	(P-4458)
2735.40	am	(P-4458)
2735.50	am	(P-4458)
2735.60	am	(P-4458)
2735.70	am	(P-4458)
2735.80	am	(P-4458)
2735.100	am	(P-4458)
2735.Ap. A	am	(P-4458)
2760.5	am	(P-4483)
2760.10	am	(P-4483)
2760.30	am	(P-4483)
2760.40	am	(P-4483)
2761.10	am	(P-4452)
2761.20	am	(P-4452)
2761.30	am	(P-4452)
2762.10	am	(P-4475)
2762.20	am	(P-4475)
2762.30	am	(P-4475)
2762.40	am	(P-4475)
2770.10	#	(P-4491)
2770.10	n	(P-4491)
2770.20	n	(P-4491)
2770.30	#	(P-4491)
2770.30	am	(P-4491)
2790.10	am	(P-4431)
2790.20	am	(P-4431)
2790.30	am	(P-4431)
2790.40	am	(P-4431)
2790.50	am	(P-4431)
2790.60	am	(P-4431)
2790.70	am	(P-4431)
2790.80	am	(P-4431)
2790.90	am	(P-4431)
2790.100	am	(P-4431)
2790.110	am	(P-4431)
2790.120	am	(P-4431)
2790.130	am	(P-4431)
2790.140	am	(P-4431)
2790.Ap.A	am	(P-4431)

TITLE 29

205.10	am	(P-5556)
205.20	am	(P-5556)
205.30	am	(P-5556)
205.40	am	(P-5556)

TITLE 32

210.10	n	(P-2003)
210.20	n	(P-2003)
210.30	n	(P-2003)
210.40	n	(P-2003)
210.50	n	(P-2003)
210.60	n	(P-2003)
210.70	n	(P-2003)
331.110	am	(P-2984)
331.120	am	(P-2984)

TITLE 32 (CONT'D)

331.130	am	(P-2984)
331.200	am	(P-2984)
331.Ap. A	r	(P-2984)
Tb. A	r	(P-2984)
Tb. B	r	(P-2984)
Tb. C	r	(P-2984)
331.Ap. B	am	(P-2984)
331.Ap. C	r	(P-2984)
340.4010	am	(P-2746)
400.120	am	(P-2739)
400.140	am	(P-2739)
400.150	am	(P-2739)
400.160	am	(P-2739)
401.70	am	(P-1474)
401.110	am	(P-1474)
401.130	am	(P-1474)
401.140	am	(P-1474)
401.150	am	(P-1474)
401.160	n	(P-1474)
401.Ap. B	am	(P-1474)
401.Ap. C	n	(P-1474)
504.10	n	(P-4163)
504.20	n	(P-4163)
504.30	n	(P-4163)
504.40	n	(P-4163)
504.50	n	(P-4163)
504.60	n	(P-4163)
504.70	n	(P-4163)

TITLE 35

212.113	am	(P-41)
212.424	am	(P-41)
212.443	am	(P-41)
212.445	am	(P-41)
215.100	am	(P-4682)
215.123	am	(P-4170)
215.215	n	(P-11059/91; A-3132)
215.583	am	(P-4170)
218.103	am	(P-4693)
218.106	am	(P-4693)
218.583	am	(P-4184)
218.586	n	(P-4184)
219.583	am	(P-4200)
219.586	n	(P-4200)
240.102	am	(P-12109/91; A-6184)
240.107	n	(P-12109/91; A-6184)
240.122	am	(P-12109/91; A-6184)
240.140	n	(P-12109/91; A-6184)
240.141	n	(P-12109/91; A-6184)
243.108	am	(P-16)
243.120	n	(P-16)
243.121	r	(P-16)
244.101	am	(P-22)
244.106	am	(P-22)
244.107	am	(P-22)
244.121	am	(P-22)
244.161	am	(P-22)
244.162	am	(P-22)
244.163	am	(P-22)
244.166	am	(P-22)
244.167	am	(P-22)
244.168	am	(P-22)
244.169	am	(P-22)
244.Ap.D	am	(P-22)
360.601	am	(P-15202/91; A-5891)
360.602	am	(P-15202/91; A-5891)
365.103	am	(P-3745)
365.104	am	(P-3745)
365.203	am	(P-3745)
365.304	am	(P-3745)
365.401	am	(P-3745)
365.402	am	(P-3745)
365.403	am	(P-3745)
365.404	am	(P-3745)
365.405	am	(P-3745)
365.503	am	(P-3745)
365.602	am	(P-3745)
365.603	am	(P-3745)
365.604	am	(P-3745)
365.803	n	(P-3745)
365.903	am	(P-3745)
365.1101	am	(P-3745)
601.105	am	(P-9829/91; O-17792/91; R-1713; A-1585)
611.101	am	(P-5582)
611.102	am	(P-5582)
611.110	am	(P-5582)
611.111	am	(P-5582)
611.112	am	(P-5582)
611.295	n	(P-5582)
611.296	n	(P-5582)
611.300	am	(P-5582)
611.301	n	(P-5582)
611.310	am	(P-5582)
611.311	am	(P-5582)
611.526	am	(P-5582)
611.591	#	(P-5582)
611.592	#	(P-5582)
611.600	n	(P-5582)
611.601	am	(P-5582)
611.602	#	(P-5582)
611.602	n	(P-5582)
611.603	#	(P-5582)
611.603	n	(P-5582)
611.604	n	(P-5582)
611.605	n	(P-5582)
611.606	am	(P-5582)
611.607	am	(P-5582)
611.608	n	(P-5582)
611.609	n	(P-5582)
611.610	#	(P-5582)
611.610	n	(P-5582)
611.611	n	(P-5582)
611.630	#	(P-5582)
611.631	n	(P-5582)
611.640	n	(P-5582)
611.641	am	(P-5582)
611.645	am	(P-5582)
611.646	n	(P-5582)
611.647	#	(P-5582)
611.647	am	(P-5582)
611.648	#	(P-5582)
611.648	n	(P-5582)
611.650	r	(P-5582)
611.657	r	(P-5582)

TITLE 35 (CONT'D)

611.658	n	(P-5582)
611.851	am	(P-5582)
611.App. A	am	(P-5582)
615.101	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.102	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.103	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.104	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.105	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.201	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.202	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.203	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.204	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.205	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.206	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.207	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.208	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.209	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.210	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.211	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.301	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.302	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.303	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.304	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.305	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.306	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.307	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.401	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.402	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.403	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.404	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.421	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.422	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.423	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.424	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.425	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.441	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.442	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.443	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.444	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.445	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.446	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.447	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.461	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.462	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.463	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.464	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.501	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.502	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.601	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.602	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.603	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.604	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.621	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.622	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.623	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.624	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.701	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.702	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.703	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.704	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.705	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.721	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.722	n	(P-10303/91; O-17791/91; R-1702; A-1538)
615.723	n	(P-10303/91; O-17791/91; R-1702; A-1538)

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615.724	n	(P-10303/91; O-17791/91; R-1702; A-1538)
616.101	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.102	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.104	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.105	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.201	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.202	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.203	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.204	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.205	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.206	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.207	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.208	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.209	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.210	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.211	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.301	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.302	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.304	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.303	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.305	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.306	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.307	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.401	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.402	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.421	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.422	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.423	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.424	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.425	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.441	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.442	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.443	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.444	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.445	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.446	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.447	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.461	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.462	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.463	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.464	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.501	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.502	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.601	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.602	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.603	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.604	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.605	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.621	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.622	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.623	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.624	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.625	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.701	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.702	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.703	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.704	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.705	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.721	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.722	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.723	n	(P-9836/91; O-17793/91; R-1723; A-1592)
616.724	n	(P-9836/91; O-17793/91; R-1723; A-1592)

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616.725	n	(P-9836/91; O-17793/91; R-1723; A-1592)
617.101	n	(P-9882/91; O-17794/91; R-1734; A-1639)
617.102	n	(P-9882/91; O-17794/91; R-1734; A-1639)
703.150	am	(P-1058)
703.155	am	(P-1058)
703.157	am	(P-1058)
703.208	n	(P-1058)
703.211	am	(P-1058)
703.232	n	(P-1058)
703.280	am	(P-1058)
703.283	am	(P-1058)
703.Ap. A	am	(P-1058)
720.110	am	(P-791)
720.111	am	(P-791)
721.102	am	(P-820)
721.103	am	(P-820)
721.104	am	(P-820)
721.106	am	(P-820)
721.120	am	(P-820)
721.131	am	(P-820) (P-15910/91; A-2600)
721.132	am	(P-820)
721.Ap. I	am	(P-9288/91; A-2155)
Tb. A	am	(P-9288/91; A-2155)
Tb. B	am	(P-9288/91; A-2155)
722.110	am	(P-1112)
720.134	am	(P-1112)
724.212	am	(P-1123)
724.440	am	(P-1123)
724.930	am	(P-1123)
724.935	am	(P-1123)
725.113	am	(P-875)
725.173	am	(P-875)
725.212	am	(P-875)
725.213	am	(P-875)
725.440	am	(P-875)
725.470	am	(P-875)
725.935	am	(P-875)
725.952	am	(P-875)
726.130	r	(P-1148)
726.131	r	(P-1148)
726.132	r	(P-1148)
726.133	r	(P-1148)
726.134	r	(P-1148)
726.135	r	(P-1148)
726.140	am	(P-1148)
726.200	n	(P-1148)
726.201	n	(P-1148)
726.202	n	(P-1148)
726.203	n	(P-1148)
726.204	n	(P-1148)
726.205	n	(P-1148)
726.206	n	(P-1148)
726.207	n	(P-1148)
726.208	n	(P-1148)
726.209	n	(P-1148)
726.210	n	(P-1148)
726.211	n	(P-1148)
726.212	n	(P-1148)
726.219	n	(P-1148)
726.Ap. A	n	(P-1148)
726.Ap. B	n	(P-1148)
726.Ap. C	n	(P-1148)
726.Ap. D	n	(P-1148)
726.Ap. E	n	(P-1148)
726.Ap. F	n	(P-1148)
726.Ap. G	n	(P-1148)
726.Ap. H	n	(P-1148)
726.Ap. I	n	(P-1148)
726.Ap. J	n	(P-1148)
726.Ap. K	n	(P-1148)
726.Ap. L	n	(P-1148)
726.Tb. A	n	(P-1148)
728.107	am	(P-916)
728.109	am	(P-916)
728.110	n	(P-916)
728.111	n	(P-916)
728.112	n	(P-916)
728.113	n	(P-916)
728.133	am	(P-916)
728.135	am	(P-916)
728.140	am	(P-916)
728.142	am	(P-916)
728.144	am	(P-916)
728.Ap. D	am	(P-916)
728.Ap. E	am	(P-916)
728.Ap. G	am	(P-916)
728.Ap. H	am	(P-916)
728.Ap. 1	n	(P-916)
728.Tb. A	am	(P-916)
728.Tb. B	am	(P-916)
728.Tb. C	am	(P-916)
728.Tb. D	am	(P-916)
728.Tb. E	am	(P-916)
731.110	am	(P-2330)
731.111	r	(P-2330)
731.112	am	(P-2330)
731.113	am	(P-2330)
731.114	r	(P-2330)
731.120	r	(P-2330)
731.121	r	(P-2330)
731.122	am	(P-2330)
731.130	r	(P-2330)
731.131	r	(P-2330)
731.132	r	(P-2330)
731.133	r	(P-2330)
731.134	r	(P-2330)
731.140	r	(P-2330)
731.141	r	(P-2330)
731.142	r	(P-2330)
731.143	r	(P-2330)
731.144	r	(P-2330)
731.145	r	(P-2330)
731.150	r	(P-2330)
731.151	r	(P-2330)
731.152	r	(P-2330)
731.153	r	(P-2330)
731.161	am	(P-2330)
731.162	am	(P-2330)
731.170	r	(P-2330)
731.171	r	(P-2330)
731.172	r	(P-2330)
731.173	r	(P-2330)

TITLE 35 (CONT'D)

731.174	r	(P-2330)
731.190	r	(P-2330)
731.191	r	(P-2330)
731.192	r	(P-2330)
731.193	r	(P-2330)
731.194	r	(P-2330)
731.195	r	(P-2330)
731.196	r	(P-2330)
731.197	r	(P-2330)
731.198	r	(P-2330)
731.199	r	(P-2330)
731.200	r	(P-2330)
731.202	r	(P-2330)
731.203	r	(P-2330)
731.204	r	(P-2330)
731.205	r	(P-2330)
731.206	r	(P-2330)
731.207	r	(P-2330)
731.208	r	(P-2330)
731.209	r	(P-2330)
731.210	r	(P-2330)
731.211	r	(P-2330)
731.Ap. A	am	(P-2330)
731.Ap. C	n	(P-2330)
809.901	r	(P-13017/91; A-130)
809.902	r	(P-13017/91; A-130)
809.903	r	(P-13017/91; A-130)
809.904	r	(P-13017/91; A-130)
809.905	r	(P-13017/91; A-130)
809.906	r	(P-13017/91; A-130)
848.101	am	(P-13004/91; A-3114)
848.202	am	(P-13004/91; A-3114)
848.205	am	(P-13004/91; A-3114)
848.206	n	(P-13004/91; A-3114)
848.207	n	(P-13004/91; A-3114)
848.208	n	(P-13004/91; A-3114)
849.101	r	(P-13265/91; A-2880)
849.102	r	(P-13265/91; A-2880)
849.103	r	(P-13265/91; A-2880)
849.104	r	(P-13265/91; A-2880)
849.105	r	(P-13265/91; A-2880)
849.106	r	(P-13265/91; A-2880)
880.100	n	(P-6127)
880.101	n	(P-6127)
880.102	n	(P-6127)
880.103	n	(P-6127)
880.104	n	(P-6127)
880.105	n	(P-6127)
880.106	n	(P-6127)
880.200	n	(P-6127)
880.201	n	(P-6127)
880.202	n	(P-6127)
880.203	n	(P-6127)
880.300	n	(P-6127)
880.301	n	(P-6127)
858.207	am	(P-4621)
1420.101	n	(P-17016/91; A-2594)
1420.102	n	(P-17016/91; A-2594)

TITLE 38

307.10	n	(P-5391)
307.20	n	(P-5391)
354.10	n	(P-5395)
354.20	n	(P-5395)
400.130	am	(P-14394/91; A-4881)
400.141	am	(P-14394/91; A-4881)
400.142	am	(P-14394/91; A-4881)
450.440	am	(P-2763) (E-2915)
450.1010	am	(P-2763) (E-2915)
450.1250	am	(P-2763) (E-2915)
450.1335	am	(P-2763) (E-2915)
450.1340	am	(P-2763) (E-2915)
1075.120	am	(P-14406/91; A-4891)

TITLE 41

170.800	n	(P-10875/91; A-4845)
170.810	n	(P-10875/91; A-4845)
170.820	n	(P-10875/91; A-4845)
170.830	n	(P-10875/91; A-4845)
170.840	n	(P-10875/91; A-4845)
170.850	n	(P-10875/91; A-4845)
170.860	n	(P-10875/91; A-4845)
170.870	n	(P-10875/91; A-4845)
170.880	n	(P-10875/91; A-4845)
170.890	n	(P-10875/91; A-4845)
170.900	n	(P-10875/91; A-4845)
170.910	n	(P-10875/91; A-4845)
215.1	n	(P-1954)
215.2	n	(P-1954)
215.20	n	(P-1954)
215.30	n	(P-1954)
215.50	n	(P-1954)
215.60	n	(P-1954)
215.70	n	(P-1954)

TITLE 44

950.110	r	(P-3695)
950.120	r	(P-3695)
950.130	r	(P-3695)
950.140	r	(P-3695)
950.150	r	(P-3695)
950.160	r	(P-3695)
950.170	r	(P-3695)
950.180	r	(P-3695)
950.210	r	(P-3695)
950.220	r	(P-3695)
950.230	r	(P-3695)
950.240	r	(P-3695)
950.250	r	(P-3695)
950.260	r	(P-3695)
950.270	r	(P-3695)
950.280	r	(P-3695)
950.290	r	(P-3695)
950.300	r	(P-3695)
5030.130	am	(P-18013/91; A-4826)

TITLE 47

100.10	am	(P-14337/91; A-3940)
100.20	am	(P-14337/91; A-3940)
100.30	am	(P-14337/91; A-3940)
100.40	am	(P-14337/91; A-3940)
100.50	am	(P-14337/91; A-3940)
100.85	am	(P-14337/91; A-3940)
100.103	am	(P-14337/91; A-3940)
100.105	am	(P-14337/91; A-3940)

TITLE 47 (CONT'D)

100.106	r	(P-14337/91; A-3940)
100.110	am	(P-14337/91; A-3940)
100.111	r	(P-14337/91; A-3940)
100.113	am	(P-14337/91; A-3940)
100.115	am	(P-14337/91; A-3940)
100.120	am	(P-14337/91; A-3940)
100.Ap. A		
Il. A	n	(P-14337/91; A-3940)
Il. B	n	(P-14337/91; A-3940)
Il. C	n	(P-14337/91; A-3940)
Il. D	n	(P-14337/91; A-3940)
Il. E	n	(P-14337/91; A-3940)
Il. F	n	(P-14337/91; A-3940)
100.Ap. D	am	(P-14337/91; A-3940)
100.Ap. E	r	(P-14337/91; A-3940)
100.Ap. F	r	(P-14337/91; A-3940)
120.30	am	(P-13993/91; A-3078)
120.55	am	(P-13993/91; A-3078)
120.80	am	(P-13993/91; A-3078)
120.90	am	(P-13993/91; A-3078)
120.110	am	(P-13993/91; A-3078)
120.115	am	(P-13993/91; A-3078)
140.10	r	(P-13241/91; A-2120)
140.20	r	(P-13241/91; A-2120)
140.30	r	(P-13241/91; A-2120)
140.40	r	(P-13241/91; A-2120)
140.50	r	(P-13241/91; A-2120)
140.60	r	(P-13241/91; A-2120)
310.101	am	(P-1961)
310.102	am	(P-1961)
310.103	am	(P-1961)
310.106	am	(P-1961)
310.107	am	(P-1961)
310.109	am	(P-1961)
310.110	am	(P-1961)
310.111	am	(P-1961)
310.113	am	(P-1961)
310.114	am	(P-1961)
310.201	am	(P-1961)
310.202	am	(P-1961)
310.203	am	(P-1961)
310.204	am	(P-1961)
310.205	am	(P-1961)
310.206	am	(P-1961)
310.301	am	(P-1961)
310.302	am	(P-1961)
310.303	am	(P-1961)
310.304	am	(P-1961)
310.305	am	(P-1961)
310.306	am	(P-1961)
310.307	am	(P-1961)
310.309	am	(P-1961)
310.401	am	(P-1961)
310.402	am	(P-1961)
310.403	am	(P-1961)
310.404	am	(P-1961)
310.405	am	(P-1961)
310.602	am	(P-1961)
310.603	am	(P-1961)
310.604	am	(P-1961)
310.701	am	(P-1961)
310.702	am	(P-1961)
310.703	am	(P-1961)
310.801	am	(P-1961)
310.802	am	(P-1961)
310.803	am	(P-1961)
310.804	am	(P-1961)
310.805	am	(P-1961)
310.806	am	(P-1961)
310.901	am	(P-1961)
310.902	am	(P-1961)
310.913	am	(P-1961)
350.213	n	(P-5185) (E-5369)

TITLE 50

904.30	am	(P-4159)
2008.10	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.20	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.30	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.40	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.50	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.60	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.61	r	(P-14859/91; PF-1743; W-2956; A-2766)
2008.70	am	(P-14859/91; PF-1743; W-2956; A-2766v)
2008.71	#	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.71	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.72	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.73	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.74	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.75	#	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.75	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.80	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.81	r	(P-14859/91; PF-1743; W-2956; A-2766)
2008.81	n	(P-14859/91; PF-1743; W-2956; A-2766)
2008.82	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.90	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.100	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.101	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.102	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.103	am	(P-14859/91; PF-1743; W-2956; A-2766)

TITLE 50 (CONT'D)

2008.104	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.110	am	(P-14859/91; PF-1743; W-2956; A-2766)
2008.Ap. A	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. B	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. C	#	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. C	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. D	r	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. D	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. E	#	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. E	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. F	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. G	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. H	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. I	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. J	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. K	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. L	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. M	#	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. M	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. N	r	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. N	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. O	#	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. O	am	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
2008.Ap. P	n	(P-14859/91; PF-1743; W-2956; A-2766; C-3590)
3113.40	am	(P-15244/91; P-5329)
3119.40	am	(P-11055/91; A-126)
6701.Ex. A	am	(P-17013/91; A-5326)

TITLE 56

120.100	n	(P-1997)
120.110	n	(P-1997)
120.120	n	(P-1997)
120.130	n	(P-1997)
120.140	n	(P-1997)
120.150	n	(P-1997)
120.160	n	(P-1997)
120.170	n	(P-1997)
250.105	am	(P-15862/91; A-5335)
250.110	r	(P-15862/91; A-5335)
250.115	r	(P-15862/91; A-5335)
250.120	r	(P-15862/91; A-5335)
250.125	r	(P-15862/91; A-5335)
250.130	r	(P-15862/91; A-5335)
250.135	r	(P-15862/91; A-5335)
250.140	r	(P-15862/91; A-5335)
250.145	r	(P-15862/91; A-5335)
250.150	r	(P-15862/91; A-5335)
250.200	am	(P-15862/91; A-5335)
250.500	am	(P-15862/91; A-5335)
250.600	am	(P-15862/91; A-5335)
250.700	am	(P-15862/91; A-5335)
250.705	n	(P-15862/91; A-5335)
250.710	n	(P-15862/91; A-5335)
250.715	n	(P-15862/91; A-5335)
250.805	am	(P-15862/91; A-5335)
250.820	am	(P-15862/91; A-5335)
250.825	am	(P-15862/91; A-5335)
250.855	n	(P-15862/91; A-5335)
250.860	n	(P-15862/91; A-5335)
300.100	r	(P-4626)
300.110	r	(P-4626)
300.120	r	(P-4626)
300.200	r	(P-4626)
300.210	r	(P-4626)
300.220	r	(P-4626)
300.230	r	(P-4626)
300.300	r	(P-4626)
300.310	r	(P-4626)
300.400	r	(P-4626)
300.410	r	(P-4626)
300.420	r	(P-4626)
300.430	r	(P-4626)
300.440	n	(P-4626)
300.450	n	(P-4626)
300.460	n	(P-4626)
300.500	n	(P-4626)
300.510	n	(P-4626)
300.520	n	(P-4626)
300.600	n	(P-4626)
300.610	n	(P-4626)
300.620	n	(P-4626)
300.630	n	(P-4626)
300.640	n	(P-4626)
300.700	n	(P-4626)
300.710	n	(P-4626)
300.720	n	(P-4626)
300.730	n	(P-4626)
300.740	n	(P-4626)
300.750	n	(P-4626)
300.760	n	(P-4626)
300.770	n	(P-4626)
300.780	n	(P-4626)
300.790	n	(P-4626)
300.800	n	(P-4626)
300.810	n	(P-4626)
300.820	n	(P-4626)
300.830	n	(P-4626)
300.840	n	(P-4626)
300.850	n	(P-4626)
300.860	n	(P-4626)
300.870	n	(P-4626)

TITLE 56 (CONT'D)

300.880	n	(P-4626)
300.890	n	(P-4626)
300.900	n	(P-4626)
300.910	n	(P-4626)
300.920	n	(P-4626)
300.930	n	(P-4626)
300.940	n	(P-4626)
300.950	n	(P-4626)
300.960	n	(P-4626)
300.970	n	(P-4626)
300.980	n	(P-4626)
300.990	n	(P-4626)
300.1000	n	(P-4626)
300.1010	n	(P-4626)
300.1020	n	(P-4626)
350.10	am	(P-1)
350.280	am	(P-1) (P-3780)
350.290	n	(P-3260)
350.300	n	(P-3260)
350.310	n	(P-3260)
350.400	n	(P-4645; C-6057)
350.410	n	(P-4645; C-6057)
350.420	n	(P-4645; C-6057)
350.430	n	(P-4645; C-6057)
350.440	n	(P-4645; C-6057)
350.450	n	(P-4645; C-6057)
350.460	n	(P-4645; C-6057)
350.Ap. A	n	(P-4645; C-6057)
350.Ap. B	n	(P-4645; C-6057)
350.Ap. C	n	(P-4645; C-6057)
350.Ap. D	n	(P-4645; C-6057)
350.Ap. E	n	(P-4645; C-6057)
1700.10	n	(P-1469)
1700.20	n	(P-1469)
1700.30	n	(P-1469)
1700.40	n	(P-1469)
1700.50	n	(P-1469)
1700.60	n	(P-1469)
2620.10	r	(P-12964/91; A-6175)
2620.20	r	(P-12964/91; A-6175)
2620.30	r	(P-12964/91; A-6175)
2620.40	r	(P-12964/91; A-6175)
2620.50	r	(P-12964/91; A-6175)
2620.60	r	(P-12964/91; A-6175)
2620.70	r	(P-12964/91; A-6175)
2620.80	r	(P-12964/91; A-6175)
2620.90	r	(P-12964/91; A-6175)
2620.100	r	(P-12964/91; A-6175)
2625.55	am	(P-5124)
2630.82	am	(P-8081/91; A-1524)
2630.83	am	(P-8081/91; A-1524)
2720.1	am	(P-14343/91; A-2556)
2720.5	am	(P-14343/91; A-2556)
2720.7	n	(P-14343/91; A-2556)
2720.10	am	(P-14343/91; A-2556)
2720.108	n	(P-14343/91; A-2556)
2720.130	am	(P-14343/91; A-2556)
2720.215	am	(P-14343/91; A-2556)
2720.240	am	(P-14343/91; A-2556)
2720.315	am	(P-14343/91; A-2556)
2725.100	am	(P-3734)
2725.105	am	(P-14014/91; A-2122)
2725.115	am	(P-14014/91; A-2122)
2725.225	am	(P-3734)
2725.237	n	(P-13252/91; A-113)
2732.203	n	(P-3248)
2732.220	n	(P-3248)
2725.245	am	(P-3734)
2732.305	n	(P-785)
2760.110	am	(P-14023/91; A-3993)
2760.120	am	(P-14023/91; A-3993)
2760.125	am	(P-14023/91; A-3993)
2760.130	am	(P-14023/91; A-3993)
2760.145	am	(P-14023/91; A-3993)
2760.150	am	(P-14023/91; A-3993)
2765.45	am	(P-14032/91; A-2131)
2765.55	am	(P-14032/91; A-2131)
2765.60	am	(P-14032/91; A-2131)
2765.68	am	(P-14032/91; A-2131)
2770.110	am	(P-13257/91; A-118)
5400.110	am	(P-1490) (E-1693)
5400.210	am	(P-1490) (E-1693)
5400.310	am	(P-1490) (E-1693)
6000.50	am	(P-5399)

TITLE 59

101.100	n	(P-14363/91; A-2137) (E-14663/91)
103.90	am	(E-2643)
115.300	am	(P-18334/91)
115.320	am	(E-2676)
119.260	am	(E-2662)
120.70	am	(E-2652)
125.70	am	(E-2672)
130.110	am	(E-2656)
132.10	n	(P-7) (E-211)
132.15	n	(P-7) (E-211)
132.20	n	(P-7) (E-211)
132.25	n	(P-7) (E-211)
132.30	n	(P-7) (E-211)
132.35	n	(P-7) (E-211)
132.40	n	(P-7) (E-211)
132.45	n	(P-7) (E-211)
132.50	n	(P-7) (E-211)
132.55	n	(P-7) (E-211)
132.60	n	(P-7) (E-211)
132.65	n	(P-7) (E-211)
132.70	n	(P-7) (E-211)
132.75	n	(P-7) (E-211)
132.80	n	(P-7) (E-211)
132.85	n	(P-7) (E-211)
132.90	n	(P-7) (E-211)
132.95	n	(P-7) (E-211)
132.100	n	(P-7) (E-211)
132.105	n	(P-7) (E-211)
132.110	n	(P-7) (E-211)
132.115	n	(P-7) (E-211)
132.120	n	(P-7) (E-211)
132.125	n	(P-7) (E-211)
132.130	n	(P-7) (E-211)
132.135	n	(P-7) (E-211)
132.140	n	(P-7) (E-211)
132.145	n	(P-7) (E-211)
132.150	n	(P-7) (E-211)
132.155	n	(P-7) (E-211)

TITLE 59 (CONT'D)

132.160	n	(P-7) (E-211)
132.165	n	(P-7) (E-211)
132.170	n	(P-7) (E-211)
132.Ap.A	n	(P-7) (E-211)
132.Ap.B	n	(P-7) (E-211)
Tb. A	n	(P-7) (E-211)
Tb. B	n	(P-7) (E-211)
Tb. C	n	(P-7) (E-211)
135.30	am	(E-2648)

TITLE 62

200.12	am	(P-3267)
200.201	am	(P-3267)
200.402	am	(P-3267)
200.500	am	(P-3267)
200.600	am	(P-3267)
200.603	am	(P-3267)
200.604	am	(P-3267)
200.806	am	(P-3267)
200.Ap. B	n	(P-3267)
220.190	am	(P-3316)
240.10	am	(P-3282)
240.500	n	(P-3282)
240.510	r	(P-3282)
240.510	n	(P-3282)
240.520	r	(P-3282)
240.520	n	(P-3282)
240.530	r	(P-3282)
240.530	n	(P-3282)
240.540	n	(P-3282)
240.550	n	(P-3282)
240.610	am	(P-3282)
240.630	am	(P-3282)
240.640	am	(P-3282)
240.710	am	(P-3282)
240.760	am	(P-3282)
240.780	am	(P-3282)
240.995	r	(P-14365/91; P-14679/91; A-2576)
240.1110	am	(P-3282)
240.1130	am	(P-3282)
240.1150	am	(P-3282)
240.1160	r	(P-3282)
240.1160	n	(P-3282)
240.1170	am	(P-3282)
240.1180	r	(P-3282)
240.1400	r	(P-14365/91; P-14679/91; A-2576)
240.1400	n	(P-14365/91; P-14679/91; A-2576)
240.1405	r	(P-14365/91; P-14679/91; A-2576)
240.1410	r	(P-14365/91; P-14679/91; A-2576)
240.1410	n	(P-14365/91; P-14679/91; A-2576)
240.1420	r	(P-14365/91; P-14679/91; A-2576)
240.1420	n	(P-14365/91; P-14679/91; A-2576)
240.1430	r	(P-14365/91; P-14679/91; A-2576) (P-3282)
240.1430	n	(P-14365/91; P-14679/91; A-2576) (P-3282)
240.1440	r	(P-14365/91; P-14679/91; A-2576)
240.1440	n	(P-14365/91; P-14679/91; A-2576)
240.1450	r	(P-14365/91; P-14679/91; A-2576) (P-3282)
240.1450	n	(P-14365/91; P-14679/91; A-2576) (P-3282)
240.1460	r	(P-14365/91; P-14679/91; A-2576) (P-3282)
240.1460	n	(P-14365/91; P-14679/91; A-2576) (P-3282)
240.1470	r	(P-14365/91; P-14679/91; A-2576)
240.1500	r	(P-14365/91; P-14679/91; A-2576)
240.1500	n	(P-14365/91; P-14679/91; A-2576)
240.1510	n	(P-14365/91; P-14679/91; A-2576)
240.1520	n	(P-14365/91; P-14679/91; A-2576)
240.1530	n	(P-14365/91; P-14679/91; A-2576)
2501.37	n	(P-2719) (E-2897)

TITLE 68

870.100	n	(P-12094/91; A-3096)
870.105	n	(P-12094/91; A-3096)
870.110	n	(P-12094/91; A-3096)
870.115	n	(P-12094/91; A-3096)
870.120	n	(P-12094/91; A-3096)
870.200	n	(P-12094/91; A-3096)
870.210	n	(P-12094/91; A-3096)
870.215	n	(P-12094/91; A-3096)
870.220	n	(P-12094/91; A-3096)
870.225	n	(P-12094/91; A-3096)
870.230	n	(P-12094/91; A-3096)
870.235	n	(P-12094/91; A-3096)
870.240	n	(P-12094/91; A-3096)
870.245	n	(P-12094/91; A-3096)
870.300	n	(P-12094/91; A-3096)
870.305	n	(P-12094/91; A-3096)
870.310	n	(P-12094/91; A-3096)
870.315	n	(P-12094/91; A-3096)
870.320	n	(P-12094/91; A-3096)
870.325	n	(P-12094/91; A-3096)
870.400	n	(P-12094/91; A-3096)
870.405	n	(P-12094/91; A-3096)
870.500	n	(P-12094/91; A-3096)
870.505	n	(P-12094/91; A-3096)
870.510	n	(P-12094/91; A-3096)
870.515	n	(P-12094/91; A-3096)
870.520	n	(P-12094/91; A-3096)
870.525	n	(P-12094/91; A-3096)
1130.10	n	(P-2010)
1130.20	n	(P-2010)
1130.30	n	(P-2010)
1130.40	n	(P-2010)
1130.50	n	(P-2010)
1130.60	n	(P-2010)

TITLE 68 (CONT'D)

1130.70	n	(P-2010)
1150.20	am	(P-2492/91; A-3143)
1150.30	am	(P-2492/91; A-3143)
1150.40	am	(P-2492/91; A-3143)
1150.50	am	(P-2492/91; A-3143)
1150.60	am	(P-2492/91; A-3143)
1150.65	am	(P-2492/91; A-3143)
1150.70	am	(P-2492/91; A-3143)
1150.80	am	(P-2492/91; A-3143)
1150.90	am	(P-2492/91; A-3143)
1150.100	am	(P-2492/91; A-3143)
1150.110	am	(P-2492/91; A-3143)
1150.Il. A	am	(P-2492/91; A-3143)
1200.30	am	(P-14369/91; A-3169)
1255.10	n	(P-17030/91; A-3194)
1255.20	n	(P-17030/91; A-3194)
1255.30	n	(P-17030/91; A-3194)
1255.40	n	(P-17030/91; A-3194)
1255.50	n	(P-17030/91; A-3194)
1255.60	n	(P-17030/91; A-3194)
1255.70	n	(P-17030/91; A-3194)
1255.80	n	(P-17030/91; A-3194)
1255.90	n	(P-17030/91; A-3194)
1275.40	am	(P-5741)
1275.50	am	(P-5741)
1275.80	n	(P-5741)
1310.20	am	(P-3784)
1310.30	am	(P-3784)
1310.40	am	(P-3784)
1310.60	am	(P-3784)
1310.70	am	(P-3784)
1310.75	am	(P-3784)
1310.80	am	(P-3784)
1310.85	am	(P-3784)
1310.90	am	(P-3784)
1330.10	am	(P-5746)
1330.20	am	(P-5746)
1330.30	am	(P-5746)
1330.40	am	(P-5746)
1330.50	am	(P-5746)
1330.55	am	(P-5746)
1330.70	am	(P-5746)
1330.75	n	(P-5746)
1330.80	am	(P-5746)
1330.90	am	(P-5746)
1330.91	am	(P-5746)
1330.92	am	(P-5746)
1330.93	am	(P-5746)
1330.94	am	(P-5746)
1330.95	am	(P-5746)
1330.96	am	(P-5746)
1330.99	am	(P-5746)
1330.100	am	(P-5746)
1330.110	am	(P-5746)
1330.120	am	(P-5746)
1330.130	am	(P-5746)
1330.140	am	(P-5746)
1340.15	n	(P-11369/91; A-3175)
1340.20	am	(P-11369/91; A-3175)
1340.30	am	(P-11369/91; A-3175)
1340.40	am	(P-11369/91; A-3175)
1340.50	am	(P-11369/91; A-3175)
1340.55	am	(P-11369/91; A-3175)
1340.60	am	(P-11369/91; A-3175)
1340.65	am	(P-11369/91; A-3175)
1340.66	n	(P-11369/91; A-3175)
1340.70	am	(P-11369/91; A-3175)
1450.175	n	(P-14375/91; A-3204)

TITLE 71

110.10	n	(P-3689)
110.20	n	(P-3689)
110.30	n	(P-3689)
110.40	n	(P-3689)
110.50	n	(P-3689)
110.60	n	(P-3689)
110.70	n	(P-3689)
2000.45	am	(P-1511)
2000.100	am	(P-1511)
2000.210	am	(P-1511)
2000.245	am	(P-1511)
2000.250	am	(P-1511)
2000.320	am	(P-1511)
2000.340	am	(P-1511)
2000.410	am	(P-1511)
2000.430	am	(P-1511)
2000.500	am	(P-1511)
2000.520	am	(P-1511)
2000.540	am	(P-1511)
2300.10	n	(P-2310)
2300.30	n	(P-2310)
2300.50	n	(P-2310)
2300.70	n	(P-2310)

TITLE 74

750.40	am	(P-15035/91; A-203)
750.Ap. B	am	(P-15035/91; A-203)
750.Ap. C	n	(P-15035/91; A-203)

TITLE 77

205.620	am	(P-3426)
250.2720	n	(P-2016)
300.110	am	(P-2034)
300.120	am	(P-4367/91; A-681)
300.140	am	(P-2034)
300.150	am	(P-2034)
300.330	am	(P-4367/91; A-681) (P-2034)
300.620	am	(P-4367/91; A-681)
300.630	am	(P-2034)
300.1010	am	(P-2034)
300.1220	am	(P-2034)
300.1240	am	(P-2034)
300.2070	am	(P-2034)
300.2420	am	(P-14039/91; A-5977)
300.3060	am	(P-2034)
300.3100	am	(P-2034)
300.3310	am	(P-2034)
300.3710	am	(P-2034)
300.Ap. B	r	(P-2034)
330.120	am	(P-4338/91; A-651)
330.330	am	(P-4338/91; A-651)
350.120	am	(P-4280/91; A-594)
350.330	am	(P-4280/91; A-594)
350.3730	am	(P-4791)

TITLE 77 (CONT'D)

390.120	am	(P-4309/91; A-623)
390.330	am	(P-4309/91; A-623)
692.10	n	(P-14389/91; A-4052)
692.Ap. A	n	(P-14389/91; A-4052)
692.Ap. B	n	(P-14389/91; A-4052)
693.10	am	(P-16874/91; RC-4556; A-5921)
693.15	am	(P-16874/91; RC-4556; A-5921)
693.30	am	(P-16874/91; RC-4556; A-5921)
693.40	am	(P-16874/91; RC-4556; A-5921)
693.45	n	(P-16874/91; RC-4556; A-5921)
693.100	am	(P-16874/91; RC-4556; A-5921)
694.220	am	(P-6972/91; A-5916)
750.5	am	(P-5836)
750.10	am	(P-5836)
750.100	am	(P-5836)
750.1000	am	(P-5836)
750.2000	n	(P-5836)
750.2010	n	(P-5836)
750.2020	n	(P-5836)
750.2030	n	(P-5836)
750.2031	n	(P-5836)
750.2032	n	(P-5836)
750.2040	n	(P-5836)
750.2041	n	(P-5836)
750.2042	n	(P-5836)
750.2050	n	(P-5836)
750.2060	n	(P-5836)
750.2070	n	(P-5836)
750.2080	n	(P-5836)
750.3000	n	(P-5836)
750.3100	n	(P-5836)
750.3200	n	(P-5836)
760.15	am	(P-5861)
760.20	am	(P-5861)
760.100	am	(P-5861)
760.110	am	(P-5861)
760.900	am	(P-5861)
760.2000	n	(P-5861)
760.2010	n	(P-5861)
760.2020	n	(P-5861)
760.2030	n	(P-5861)
760.2031	n	(P-5861)
760.2032	n	(P-5861)
760.2040	n	(P-5861)
760.2041	n	(P-5861)
760.2042	n	(P-5861)
760.2050	n	(P-5861)
760.2060	n	(P-5861)
760.2070	n	(P-5861)
760.2080	n	(P-5861)
760.3000	n	(P-5861)
760.3100	n	(P-5861)
760.3200	n	(P-5861)
770.10	r	(P-5885)
770.20	r	(P-5885)
770.30	r	(P-5885)
790.40	am	(P-15943/91; A-5941)
790.480	am	(P-4782) (E-4899)
790.500	am	(P-4782) (E-4899)
790.540	am	(P-4782) (E-4899)
790.548	am	(P-4782) (E-4899)
790.580	am	(P-4782) (E-4899)
790.600	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.620	am	(P-4782) (E-4899)
790.660	am	(P-4782) (E-4899)
790.700	am	(P-4782) (E-4899)
790.706	am	(P-4782) (E-4899)
790.721	am	(P-4782) (E-4899)
790.740	am	(P-4782) (E-4899)
790.760	am	(P-4782) (E-4899)
790.780	am	(P-4782) (E-4899)
790.788	am	(P-4782) (E-4899)
790.799	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.820	am	(P-4782) (E-4899)
790.830	am	(P-4782) (E-4899)
790.860	am	(P-4782) (E-4899)
790.900	am	(P-4782) (E-4899)
790.910	am	(P-4782) (E-4899)
790.920	am	(P-15943/91; A-5941)
790.980	am	(P-4782) (E-4899)
790.1060	am	(P-4782) (E-4899)
790.1112	am	(P-4782) (E-4899)
790.1120	am	(P-4782) (E-4899)
790.1140	am	(P-4782) (E-4899)
790.1300	am	(P-4782) (E-4899)
790.1345	am	(P-4782) (E-4899)
790.1350	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.1388	n	(P-15943/91; A-5941) (P-4782) (E-4899)
790.1420	am	(P-4782) (E-4899)
790.1460	am	(P-4782) (E-4899)
790.1490	am	(P-4782) (E-4899)
790.1500	am	(P-4782) (E-4899)
790.1540	am	(P-4782) (E-4899)
790.1560	am	(P-4782) (E-4899)
790.1570	am	(P-4782) (E-4899)
790.1660	am	(P-4782) (E-4899)
790.1685	am	(P-4782) (E-4899)
790.1700	am	(P-4782) (E-4899)
790.1710	am	(P-4782) (E-4899)
790.1740	am	(P-4782) (E-4899)
790.1820	am	(P-4782) (E-4899)
790.1830	n	(P-4782) (E-4899)
790.1860	am	(P-4782) (E-4899)
790.1950	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.1980	am	(P-4782) (E-4899)
790.2020	am	(P-4782) (E-4899)
790.2097	am	(P-4782) (E-4899)
790.2100	am	(P-4782) (E-4899)
790.2140	am	(P-4782) (E-4899)
790.2155	am	(P-4782) (E-4899)
790.2180	am	(P-4782) (E-4899)
790.2260	am	(P-4782) (E-4899)
790.2380	am	(P-4782) (E-4899)
790.2390	am	(P-4782) (E-4899)
790.2460	am	(P-4782) (E-4899)
790.2462	am	(P-4782) (E-4899)
790.2470	am	(P-4782) (E-4899)
790.2485	am	(P-15943/91; A-5941)
790.2500	am	(P-4782) (E-4899)
790.2510	am	(P-4782) (E-4899)

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790.2603	am	(P-15943/91; A-5941)
790.2605	am	(P-4782) (E-4899)
790.2613	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.2617	am	(P-4782) (E-4899)
790.2618	am	(P-4782) (E-4899)
790.2620	am	(P-4782) (E-4899)
790.2661	am	(P-4782) (E-4899)
790.2780	am	(P-4782) (E-4899)
790.2805	am	(P-15943/91; A-5941)
790.2900	am	(P-4782) (E-4899)
790.2902	am	(P-4782) (E-4899)
790.2904	am	(P-4782) (E-4899)
790.2980	am	(P-4782) (E-4899)
790.3020	am	(P-4782) (E-4899)
790.3021	am	(P-4782) (E-4899)
790.3027	am	(P-15943/91; A-5941)
790.3029	am	(P-4782) (E-4899)
790.3049	am	(P-4782) (E-4899)
790.3054	am	(P-4782) (E-4899)
790.3085	am	(P-4782) (E-4899)
790.3100	am	(P-4782) (E-4899)
790.3260	am	(P-4782) (E-4899)
790.3300	am	(P-4782) (E-4899)
790.3308	am	(P-4782) (E-4899)
790.3315	am	(P-4782) (E-4899)
790.3335	am	(P-4782) (E-4899)
790.3340	am	(P-4782) (E-4899)
790.3420	am	(P-4782) (E-4899)
790.3437	am	(P-4782) (E-4899)
790.3472	am	(P-4782) (E-4899)
790.3480	n	(P-4782) (E-4899)
790.3492	am	(P-4782) (E-4899)
790.3495	n	(P-4782) (E-4899)
790.3540	am	(P-4782) (E-4899)
790.3620	am	(P-4782) (E-4899)
790.3700	am	(P-4782) (E-4899)
790.3742	am	(P-4782) (E-4899)
790.3780	am	(P-4782) (E-4899)
790.3860	am	(P-4782) (E-4899)
790.3875	n	(P-4782) (E-4899)
790.3907	am	(P-4782) (E-4899)
790.3910	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.3940	am	(P-4782) (E-4899)
790.3945	am	(P-4782) (E-4899)
790.3980	am	(P-4782) (E-4899)
790.3996	am	(P-4782) (E-4899)
790.4012	am	(P-4782) (E-4899)
790.4040	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.4060	am	(P-4782) (E-4899)
790.4100	am	(P-4782) (E-4899)
790.4140	am	(P-4782) (E-4899)
790.4173	am	(P-4782) (E-4899)
790.4180	am	(P-4782) (E-4899)
790.4220	am	(P-4782) (E-4899)
790.4260	am	(P-4782) (E-4899)
790.4300	am	(P-4782) (E-4899)
790.4385	am	(P-4782) (E-4899)
790.4386	am	(P-4782) (E-4899)
790.4396	am	(P-4782) (E-4899)
790.4398	am	(P-4782) (E-4899)
790.4420	am	(P-4782) (E-4899)
790.4580	am	(P-4782) (E-4899)
790.4620	am	(P-4782) (E-4899)
790.4660	am	(P-4782) (E-4899)
790.4670	am	(P-4782) (E-4899)
790.4680	am	(P-4782) (E-4899)
790.4700	am	(P-4782) (E-4899)
790.4720	am	(P-4782) (E-4899)
790.4740	am	(P-4782) (E-4899)
790.4780	am	(P-4782) (E-4899)
790.4840	am	(P-4782) (E-4899)
790.4860	am	(P-4782) (E-4899)
790.4900	am	(P-4782) (E-4899)
790.4965	am	(P-4782) (E-4899)
790.4980	am	(P-4782) (E-4899)
790.5060	am	(P-4782) (E-4899)
790.5100	am	(P-4782) (E-4899)
790.5140	am	(P-4782) (E-4899)
790.5180	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.5220	am	(P-4782) (E-4899)
790.5300	am	(P-4782) (E-4899)
790.5312	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.5320	am	(P-15943/91; A-5941)
790.5380	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.5420	am	(P-4782) (E-4899)
790.5483	am	(P-4782) (E-4899)
790.5500	am	(P-4782) (E-4899)
790.5520	am	(P-4782) (E-4899)
790.5540	am	(P-4782) (E-4899)
790.5544	am	(P-4782) (E-4899)
790.5620	am	(P-4782) (E-4899)
790.5640	am	(P-15943/91; A-5941)
790.5700	am	(P-4782) (E-4899)
790.5740	am	(P-4782) (E-4899)
790.5788	n	(P-4782) (E-4899)
790.5792	am	(P-4782) (E-4899)
790.5802	am	(P-4782) (E-4899)
790.5807	am	(P-4782) (E-4899)
790.5820	am	(P-4782) (E-4899)
790.5830	am	(P-4782) (E-4899)
790.5872	am	(P-4782) (E-4899)
790.5900	am	(P-4782) (E-4899)
790.5940	am	(P-4782) (E-4899)
790.5980	am	(P-4782) (E-4899)
790.6020	r	(P-4782) (E-4899)
790.6140	am	(P-4782) (E-4899)
790.6180	am	(P-4782) (E-4899)
790.6260	am	(P-4782) (E-4899)
790.6275	am	(P-4782) (E-4899)
790.6277	am	(P-4782) (E-4899)
790.6280	r	(P-4782) (E-4899)
790.6300	am	(P-4782) (E-4899)
790.6340	am	(P-4782) (E-4899)
790.6370	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.6375	am	(P-4782) (E-4899)

TITLE 77 (CONT'D)

790.6420	am	(P-4782) (E-4899)
790.6452	am	(P-4782) (E-4899)
790.6456	am	(P-4782) (E-4899)
790.6460	am	(P-4782) (E-4899)
790.6480	am	(P-4782) (E-4899)
790.6500	am	(P-4782) (E-4899)
790.6540	am	(P-4782) (E-4899)
790.6570	r	(P-4782) (E-4899)
790.6580	am	(P-4782) (E-4899)
790.6670	am	(P-4782) (E-4899)
790.6780	am	(P-4782) (E-4899)
790.6800	am	(P-4782) (E-4899)
790.6820	am	(P-4782) (E-4899)
790.6860	am	(P-4782) (E-4899)
790.6875	am	(P-4782) (E-4899)
790.6885	am	(P-4782) (E-4899)
790.6895	am	(P-4782) (E-4899)
790.6940	am	(P-4782) (E-4899)
790.6960	am	(P-4782) (E-4899)
790.6980	am	(P-4782) (E-4899)
790.7100	am	(P-4782) (E-4899)
790.7120	am	(P-4782) (E-4899)
790.7130	am	(P-4782) (E-4899)
790.7140	am	(P-4782) (E-4899)
790.7180	am	(P-4782) (E-4899)
790.7229	am	(P-4782) (E-4899)
790.7260	am	(P-4782) (E-4899)
790.7263	n	(P-4782) (E-4899)
790.7265	am	(P-4782) (E-4899)
790.7280	am	(P-4782) (E-4899)
790.7291	am	(P-4782) (E-4899)
790.7296	am	(P-4782) (E-4899)
790.7380	am	(P-4782) (E-4899)
790.7400	am	(P-4782) (E-4899)
790.7420	am	(P-4782) (E-4899)
790.7500	am	(P-4782) (E-4899)
790.7510	am	(P-4782) (E-4899)
790.7540	am	(P-4782) (E-4899)
790.7580	am	(P-4782) (E-4899)
790.7700	am	(P-4782) (E-4899)
790.7740	am	(P-4782) (E-4899)
790.7820	am	(P-4782) (E-4899)
790.7828	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.7834	am	(P-4782) (E-4899)
790.7860	am	(P-4782) (E-4899)
790.7940	am	(P-4782) (E-4899)
790.7980	am	(P-4782) (E-4899)
790.8015	am	(P-4782) (E-4899)
790.8020	am	(P-4782) (E-4899)
790.8106	am	(P-4782) (E-4899)
790.8136	am	(P-4782) (E-4899)
790.8248	am	(P-4782) (E-4899)
790.8300	am	(P-4782) (E-4899)
790.8420	am	(P-4782) (E-4899)
790.8540	am	(P-4782) (E-4899)
790.8580	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.8620	am	(P-4782) (E-4899)
790.8700	am	(P-4782) (E-4899)
790.8710	am	(P-4782) (E-4899)
790.8724	am	(P-4782) (E-4899)
790.8740	am	(P-4782) (E-4899)
790.8780	am	(P-4782) (E-4899)
790.8820	am	(P-4782) (E-4899)
790.8900	am	(P-4782) (E-4899)
790.8940	am	(P-4782) (E-4899)
790.8980	am	(P-4782) (E-4899)
790.9020	am	(P-4782) (E-4899)
790.9035	am	(P-4782) (E-4899)
790.9045	am	(P-4782) (E-4899)
790.9048	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.9050	am	(P-15943/91; A-5941)
790.9056	am	(P-4782) (E-4899)
790.9060	am	(P-4782) (E-4899)
790.9084	am	(P-4782) (E-4899)
790.9100	am	(P-15943/91; A-5941) (P-4782) (E-4899)
790.9140	am	(P-4782) (E-4899)
790.9180	am	(P-4782) (E-4899)
790.9220	am	(P-4782) (E-4899)
790.9260	am	(P-4782) (E-4899)
790.9300	am	(P-4782) (E-4899)
790.9340	am	(P-4782) (E-4899)
790.9380	am	(P-4782) (E-4899)
790.9420	am	(P-4782) (E-4899)
790.9460	am	(P-4782) (E-4899)
790.9500	am	(P-4782) (E-4899)
790.9520	am	(P-4782) (E-4899)
790.9530	am	(P-4782) (E-4899)
790.9580	am	(P-4782) (E-4899)
830.10	am	(P-2092)
830.880	am	(P-2092)
830.885	am	(P-2092)
830.890	am	(P-2092)
830.900	am	(P-2092)
840.20	am	(P-4329)
840.115	am	(P-4329)
840.210	am	(P-4329)
840.215	am	(P-4329)
840.305	am	(P-4329)
840.310	am	(P-4329)
840.Ap. B Ex. A	am	(P-4329)
Il. A	r	(P-4329)
Ex. B	n	(P-4329)
Il. B	am	(P-4329)
840.Ap. C Ex.B	am	(P-4329)
1120.10	n	(P-5205)
1120.20	n	(P-5205)
1120.110	n	(P-5205)
1120.120	n	(P-5205)
1120.130	n	(P-5205)
1120.210	n	(P-5205)
1120.310	n	(P-5205)
1120.Ap. A	n	(P-5205)
1130.140	am	(P-4755)
1130.220	am	(P-4755)
1130.410	am	(P-4755)
1130.510	am	(P-4755)
1130.620	am	(P-4755)
1130.630	am	(P-4755)
1130.640	am	(P-4755)

TITLE 77 (CONT'D)

1130.710	am	(P-4755)
1130.720	am	(P-4755)
1130.730	am	(P-4755)
1130.740	am	(P-4755)
1130.760	am	(P-4755)
1130.770	am	(P-4755)
1130.780	am	(P-4755)
1190.30	am	(P-3063)
1230.10	r	(P-5187)
1230.20	r	(P-5187)
1230.30	r	(P-5187)
1230.110	r	(P-5187)
1230.120	r	(P-5187)
1230.210	r	(P-5187)
1230.220	r	(P-5187)
1230.230	r	(P-5187)
1230.240	r	(P-5187)
1230.250	r	(P-5187)
1230.260	r	(P-5187)
1230.310	r	(P-5187)
1230.320	r	(P-5187)
1230.410	r	(P-5187)
1230.420	r	(P-5187)
1230.Tb. A	r	(P-5187)
1230.Tb. B	r	(P-5187)
1240.10	r	(P-5225)
1240.20	r	(P-5225)
1240.30	r	(P-5225)
1240.40	r	(P-5225)
1240.50	r	(P-5225)
1240.60	r	(P-5225)
1240.70	r	(P-5225)
1240.Ap. A	r	(P-5225)
2030.10	n	(P-9083/91; A-2457)
2030.10	r	(P-9153/91; A-2530)
2030.20	n	(P-9083/91; A-2457)
2030.20	r	(P-9153/91; A-2530)
2030.30	n	(P-9083/91; A-2457)
2030.30	r	(P-9153/91; A-2530)
2030.40	n	(P-9083/91; A-2457)
2030.40	r	(P-9153/91; A-2530)
2030.50	r	(P-9153/91; A-2530)
2030.100	n	(P-9083/91; A-2457)
2030.105	n	(P-9083/91; A-2457)
2030.107	n	(P-9083/91; A-2457)
2030.110	n	(P-9083/91; A-2457)
2030.110	r	(P-9153/91; A-2530)
2030.115	n	(P-9083/91; A-2457)
2030.120	n	(P-9083/91; A-2457)
2030.120	r	(P-9153/91; A-2530)
2030.130	n	(P-9083/91; A-2457)
2030.130	r	(P-9153/91; A-2530)
2030.140	n	(P-9083/91; A-2457)
2030.150	n	(P-9083/91; A-2457)
2030.160	n	(P-9083/91; A-2457)
2030.210	n	(P-9083/91; A-2457)
2030.210	r	(P-9153/91; A-2530)
2030.220	n	(P-9083/91; A-2457)
2030.220	r	(P-9153/91; A-2530)
2030.230	n	(P-9083/91; A-2457)
2030.230	r	(P-9153/91; A-2530)
2030.310	n	(P-9083/91; A-2457)
2030.310	r	(P-9153/91; A-2530)
2030.320	n	(P-9083/91; A-2457)
2030.320	r	(P-9153/91; A-2530)
2030.330	n	(P-9083/91; A-2457)
2030.330	r	(P-9153/91; A-2530)
2030.340	n	(P-9083/91; A-2457)
2030.340	r	(P-9153/91; A-2530)
2030.350	n	(P-9083/91; A-2457)
2030.350	r	(P-9153/91; A-2530)
2030.360	n	(P-9083/91; A-2457)
2030.410	n	(P-9083/91; A-2457)
2030.410	r	(P-9153/91; A-2530)
2030.420	n	(P-9083/91; A-2457)
2030.420	r	(P-9153/91; A-2530)
2030.430	n	(P-9083/91; A-2457)
2030.430	r	(P-9153/91; A-2530)
2030.440	n	(P-9083/91; A-2457)
2030.440	r	(P-9153/91; A-2530)
2030.450	n	(P-9083/91; A-2457)
2030.450	r	(P-9153/91; A-2530)
2030.510	n	(P-9083/91; A-2457)
2030.510	r	(P-9153/91; A-2530)
2030.520	n	(P-9083/91; A-2457)
2030.520	r	(P-9153/91; A-2530)
2030.530	n	(P-9083/91; A-2457)
2030.540	n	(P-9083/91; A-2457)
2030.550	n	(P-9083/91; A-2457)
2030.610	n	(P-9083/91; A-2457)
2030.610	r	(P-9153/91; A-2530)
2030.620	n	(P-9083/91; A-2457)
2030.620	r	(P-9153/91; A-2530)
2030.630	r	(P-9153/91; A-2530)
2030.640	r	(P-9153/91; A-2530)
2030.710	n	(P-9083/91; A-2457)
2030.710	r	(P-9153/91; A-2530)
2030.720	n	(P-9083/91; A-2457)
2030.720	r	(P-9153/91; A-2530)
2030.730	n	(P-9083/91; A-2457)
2030.730	r	(P-9153/91; A-2530)
2030.740	n	(P-9083/91; A-2457)
2030.740	r	(P-9153/91; A-2530)
2030.750	n	(P-9083/91; A-2457)
2030.750	r	(P-9153/91; A-2530)
2030.760	n	(P-9083/91; A-2457)
2030.760	r	(P-9153/91; A-2530)
2030.810	n	(P-9083/91; A-2457)
2030.810	r	(P-9153/91; A-2530)
2030.820	n	(P-9083/91; A-2457)
2030.820	r	(P-9153/91; A-2530)
2030.830	n	(P-9083/91; A-2457)
2030.840	n	(P-9083/91; A-2457)
2030.850	n	(P-9083/91; A-2457)
2030.910	n	(P-9083/91; A-2457)
2030.910	r	(P-9153/91; A-2530)
2030.920	r	(P-9153/91; A-2530)
2030.930	r	(P-9153/91; A-2530)
2030.940	r	(P-9153/91; A-2530)
2030.950	r	(P-9153/91; A-2530)
2030.960	r	(P-9153/91; A-2530)
2030.970	r	(P-9153/91; A-2530)
2030.980	r	(P-9153/91; A-2530)
2030.1010	n	(P-9083/91; A-2457)
2030.1010	r	(P-9153/91; A-2530)

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2030.1020	n	(P-9083/91; A-2457)
2030.1020	r	(P-9153/91; A-2530)
2030.1030	n	(P-9083/91; A-2457)
2030.1030	r	(P-9153/91; A-2530)
2030.1040	n	(P-9083/91; A-2457)
2030.1040	r	(P-9153/91; A-2530)
2030.1050	n	(P-9083/91; A-2457)
2030.1060	n	(P-9083/91; A-2457)
2030.1070	n	(P-9083/91; A-2457)
2030.1080	n	(P-9083/91; A-2457)
2030.1090	n	(P-9083/91; A-2457)
2030.1110	n	(P-9083/91; A-2457)
2030.1110	r	(P-9153/91; A-2530)
2030.1120	n	(P-9083/91; A-2457)
2030.1120	r	(P-9153/91; A-2530)
2030.1130	n	(P-9083/91; A-2457)
2030.1130	r	(P-9153/91; A-2530)
2030.1140	r	(P-9153/91; A-2530)
2030.1140	n	(P-9083/91; A-2457)
2030.1150	n	(P-9083/91; A-2457)
2030.1160	n	(P-9083/91; A-2457)
2030.1205	n	(P-9083/91; A-2457)
2030.1210	n	(P-9083/91; A-2457)
2030.1210	r	(P-9153/91; A-2530)
2030.1215	n	(P-9083/91; A-2457)
2030.1220	r	(P-9153/91; A-2530)
2030.1220	n	(P-9083/91; A-2457)
2030.1225	n	(P-9083/91; A-2457)
2030.1225	n	(P-9083/91; A-2457)
2030.1230	r	(P-9153/91; A-2530)
2030.1230	n	(P-9083/91; A-2457)
2030.1240	r	(P-9153/91; A-2530)
2030.1245	n	(P-9083/91; A-2457)
2030.1250	r	(P-9153/91; A-2530)
2030.1250	n	(P-9083/91; A-2457)
2030.1255	n	(P-9083/91; A-2457)
2030.1260	r	(P-9153/91; A-2530)
2030.1265	n	(P-9083/91; A-2457)
2030.1270	r	(P-9153/91; A-2530)
2030.1310	n	(P-9083/91; A-2457)
2030.1310	r	(P-9153/91; A-2530)
2030.1320	n	(P-9083/91; A-2457)
2030.1320	r	(P-9153/91; A-2530)
2030.1330	r	(P-9153/91; A-2530)
2030.1340	r	(P-9153/91; A-2530)
2030.1350	r	(P-9153/91; A-2530)
2031.10	r	(P-9149/91; A-2455)
2032.10	r	(P-9218/91; A-2533)
2032.15	r	(P-9218/91; A-2533)
2032.20	r	(P-9218/91; A-2533)
2032.25	r	(P-9218/91; A-2533)
2032.30	r	(P-9218/91; A-2533)
2032.35	r	(P-9218/91; A-2533)
2032.40	r	(P-9218/91; A-2533)
2032.45	r	(P-9218/91; A-2533)
2032.50	r	(P-9218/91; A-2533)
2032.55	r	(P-9218/91; A-2533)
2032.60	r	(P-9218/91; A-2533)
2056.1	am	(P-4567)
2056.5	am	(P-4567)
2056.15	am	(P-4567)
2056.20	am	(P-4567)
2056.25	am	(P-4567)
2056.50	am	(P-4567)
2056.55	am	(P-4567)
2056.60	am	(P-4567)
2056.61	am	(P-4567)
2056.65	#	(P-4567)
2056.70	#	(P-4567)
2056.75	am	(P-4567)
2056.210	am	(P-4567)
2056.215	am	(P-4567)
2056.301	#	(P-4567)
2056.301	am	(P-4567)
2056.303	#	(P-4567)
2056.303	am	(P-4567)
2056.305	am	(P-4567)
2056.310	am	(P-4567)
2056.315	am	(P-4567)
2056.320	am	(P-4567)
2056.325	am	(P-4567)
2056.330	am	(P-4567)
2056.405	am	(P-4567)
2056.410	am	(P-4567)
2056.415	am	(P-4567)
2056.420	am	(P-4567)
2056.500	am	(P-4567)
2056.505	am	(P-4567)
2056.510	r	(P-4567)
2056.525	am	(P-4567)
2056.600	am	(P-4567)
2056.601	n	(P-4567)
2056.603	n	(P-4567)
2056.605	am	(P-4567)
2056.607	n	(P-4567)
2056.610	am	(P-4567)
2056.615	r	(P-4567)
2056.620	n	(P-4567)
2056.625	n	(P-4567)
2056.630	n	(P-4567)
2056.635	n	(P-4567)
2056.640	n	(P-4567)
2056.645	n	(P-4567)
2056.650	n	(P-4567)
2056.655	n	(P-4567)
2056.660	n	(P-4567)
2056.705	am	(P-4567)
2090.20	am	(P-5104)
2090.40	am	(P-5104)
2090.70	am	(P-5104)
2090.90	am	(P-5104)
2090.100	am	(P-5104)

TITLE 80

150.410	am	(P-4360)
150.420	am	(P-4360)
150.430	am	(P-4360)
302.80	am	(P-336)
303.102	am	(P-327)
303.115	n	(P-327)
303.125	am	(P-327)
303.175	n	(P-327)
303.290	am	(P-327)
303.385	n	(P-327)
304.51	n	(P-334)

TITLE 80 (CONT'D)

310.100	am	(P-342) (E-711)
310.110	am	(P-12051/91; A-3450)
310.130	am	(P-12051/91; A-3450)
310.230	am	(P-342)
310.280	am	(P-12051/91; A-3450)
310.290	am	(P-12051/91; A-3450)
310.490	am	(P-342) (E-711)
310.Ap. A	am	(P-342) (PP-5068)
310.Tb. C	am	(P-342)
310.Tb. D	am	(P-342)
310.Tb. E	am	(P-342)
310.Tb. F	am	(P-342)
310.Tb. G	am	(P-342)
310.Tb. H	am	(P-342)
310.Tb. I	am	(P-342)
310.Tb. J	am	(P-342)
310.Tb. K	am	(P-342)
310.Tb. O	am	(P-342)
310.Tb. P	am	(P-342)
310.Tb. Q	am	(P-342)
310.Tb. R	am	(P-342)
310.Tb. S	am	(P-342)
310.Tb. T	am	(PP-5068)
310.Tb. V	am	(PP-5068)
310.Tb. W	am	(P-342)
310.Tb. X	am	(P-342)
310.Tb. Y	am	(P-342)
310.Tb. Z	am	(P-342)
310.Ap. B	am	(P-12051/91; A-3450)
1120.80	n	(P-5554) (E-6052)
2650.10	am	(P-3235)
2650.25	am	(P-3235)
2800.650	n	(P-15199/91; A-4831)

TITLE 83

200.715	n	(P-1936)
305.20	am	(P-16538/91; A-6180)
410.360	r	(P-11899/91; A-2544)
445.40	am	(P-11025/91; A-2535)
445.50	am	(P-11025/91; A-2535)
445.70	am	(P-11025/91; A-2535)
500.335	r	(P-11905/91; A-2550)
760.20	am	(P-14340/91; A-6177) (P-16535/91; A-6177)
770.10	n	(P-3242)
770.20	n	(P-3242)
770.30	n	(P-3242)

TITLE 86

110.190	n	(P-14196/91; A-2624)
130.310	am	(P-15013/91; A-1642)
180.101	am	(P-(P-15948/91; A-4859)
180.130	am	(P-(P-15948/91; A-4859)
180.140	am	(P-(P-15948/91; A-4859)
180.145	am	(P-(P-15948/91; A-4859)
190.101	am	(P-15958/91; A-4867)
190.110	am	(P-15958/91; A-4867)
190.120	am	(P-15958/91; A-4867)
190.170	am	(P-15958/91; A-4867)
190.175	am	(P-15958/91; A-4867)
460.101	am	(P-15417/91; A-4876)
460.110	am	(P-15417/91; A-4876)
480.101	am	(P-15422/91; A-3578)
490.10	r	(P-16913/91; A-5988)
490.20	r	(P-16913/91; A-5988)
490.30	r	(P-16913/91; A-5988)
490.40	r	(P-16913/91; A-5988)
490.50	r	(P-16913/91; A-5988)
490.60	r	(P-16913/91; A-5988)
490.70	r	(P-16913/91; A-5988)
490.80	r	(P-16913/91; A-5988)
490.90	r	(P-16913/91; A-5988)
490.100	r	(P-16913/91; A-5988)
490.110	r	(P-16913/91; A-5988)
490.120	r	(P-16913/91; A-5988)
490.130	r	(P-16913/91; A-5988)
490.140	r	(P-16913/91; A-5988)
490.150	r	(P-16913/91; A-5988)
490.160	r	(P-16913/91; A-5988)
490.170	r	(P-16913/91; A-5988)
490.180	r	(P-16913/91; A-5988)
490.190	r	(P-16913/91; A-5988)
490.200	r	(P-16913/91; A-5988)
510.101	am	(P-16932/91; A-5990)
510.110	am	(P-16932/91; A-5990)
510.115	r	(P-16932/91; A-5990)
510.120	am	(P-16932/91; A-5990)
510.131	am	(P-16932/91; A-5990)
510.145	am	(P-16932/91; A-5990)
510.160	am	(P-16932/91; A-5990)
3000.100	am	(P-3802)
3000.200	am	(P-3802)
3000.210	am	(P-3802)
3000.220	am	(P-3802)
3000.230	am	(P-3802)
3000.245	am	(P-3802)
3000.270	am	(P-3802)
3000.420	am	(P-3802)
3000.425	am	(P-3802)
3000.610	am	(P-3802)
3000.620	am	(P-3802)
3000.625	am	(P-3802)
3000.645	am	(P-3802)
3000.910	am	(P-3802)
3000.1010	am	(P-3802)
3000.1070	am	(P-3802)

TITLE 89

104.202	am	(P-4741)
104.204	am	(P-4741)
104.206	am	(P-2752)
104.208	am	(P-2752)
104.209	n	(P-4741)
104.210	am	(P-2752) (P-4741)
104.212	am	(P-4741)
104.221	am	(P-4741)
104.230	am	(P-4741)
104.244	am	(P-4741)
104.246	am	(P-4741)
104.272	am	(P-2752)
104.273	am	(P-2752)
104.274	am	(P-2752)
110.10	am	(P-16845/91)
110.30	am	(P-3405; W-5082) (P-4704)
112.70	am	(P-3335)

TITLE 89 (CONT'D)

112.71	am	(P-3335)
112.72	am	(P-3335)
112.74	am	(P-3335)
112.78	am	(P-3335)
112.79	am	(P-3335)
112.82	am	(P-3335)
113.40	am	(P-14994/91; A-3468)
113.50	am	(P-14994/91; A-3468)
113.302	r	(P-14994/91; A-3468)
113.400	n	(P-14994/91; A-3468)
113.405	n	(P-14994/91; A-3468)
113.410	n	(P-14994/91; A-3468)
113.415	n	(P-14994/91; A-3468)
113.420	n	(P-14994/91; A-3468)
113.425	n	(P-14994/91; A-3468)
113.430	n	(P-14994/91; A-3468)
113.435	n	(P-14994/91; A-3468)
113.440	#	(P-14994/91; A-3468)
113.440	am	(P-14994/91; A-3468)
113.445	n	(P-14994/91; A-3468)
114.1	am	(P-15008/91; A-3512)
114.2	n	(P-15008/91; A-3512)
114.60	am	(P-15008/91; A-3512)
114.61	am	(P-15008/91; A-3512)
114.62	am	(P-15008/91; A-3512)
114.63	am	(P-15008/91; A-3512)
114.64	am	(P-15008/91; A-3512)
114.70	am	(P-15008/91; A-3512)
114.80	am	(P-15008/91; A-3512)
114.120	am	(P-15008/91; A-3512)
114.121	am	(P-15008/91; A-3512)
114.122	r	(P-15008/91; A-3512)
114.123	r	(P-15008/91; A-3512)
114.124	am	(P-15008/91; A-3512)
114.128	am	(P-4216) (E-4540)
114.135	am	(P-4216) (E-4540)
114.400	am	(P-15008/91; A-3512)
114.420	am	(P-15008/91; A-3512)
116.500	am	(P-16623/91; A-5350)
116.520	am	(P-16623/91; A-5350)
120.50	r	(P-12137/91; A-139)
120.200	n	(P-12137/91; A-139)
120.208	r	(P-12137/91; A-139)
120.210	r	(P-12137/91; A-139)
120.211	r	(P-12137/91; A-139)
120.212	r	(P-12137/91; A-139)
120.215	r	(P-12137/91; A-139)
120.216	r	(P-12137/91; A-139)
120.217	r	(P-12137/91; A-139)
120.218	r	(P-12137/91; A-139)
120.224	r	(P-12137/91; A-139)
120.225	r	(P-12137/91; A-139)
120.230	r	(P-12137/91; A-139)
120.235	r	(P-12137/91; A-139)
120.236	r	(P-12137/91; A-139)
120.240	r	(P-12137/91; A-139)
120.245	r	(P-12137/91; A-139)
120.250	r	(P-12137/91; A-139)
120.255	r	(P-12137/91; A-139)
120.260	r	(P-12137/91; A-139)
120.261	r	(P-12137/91; A-139)
120.262	r	(P-12137/91; A-139)
120.270	r	(P-12137/91; A-139)
120.271	r	(P-12137/91; A-139)
120.272	r	(P-12137/91; A-139)
120.273	r	(P-12137/91; A-139)
120.275	r	(P-12137/91; A-139)
120.276	r	(P-12137/91; A-139)
120.280	r	(P-12137/91; A-139)
120.281	r	(P-12137/91; A-139)
120.282	r	(P-12137/91; A-139)
120.283	r	(P-12137/91; A-139)
120.284	r	(P-12137/91; A-139)
120.285	r	(P-12137/91; A-139)
120.290	r	(P-12137/91; A-139)
120.295	r	(P-12137/91; A-139)
120.319	am	(P-833/91; A-1862)
120.320	am	(P-833/91; A-1862)
120.321	am	(P-833/91; A-1862)
120.322	am	(P-833/91; A-1862)
120.323	am	(P-833/91; A-1862)
121.58	am	(P-2420)
121.63	am	(E-757)
121.72	am	(P-2420)
121.73	am	(P-2420)
140.2	am	(P-17171/91; A-174)
140.5	am	(P-17171/91; A-174)
140.11	am	(P-6949/91; A-3552)
140.13	am	(P-4708)
140.14	am	(P-4708)
140.16	am	(P-4708)
140.19	am	(P-4708)
140.27	am	(P-65) (E-300)
140.31	n	(P-4708)
140.32	n	(P-4708)
140.33	n	(P-4708)
140.94	n	(P-15933/91; A-6408)
140.95	n	(P-15933/91; A-6408)
140.440	am	(P-12171/91; A-4006)
140.441	am	(P-12171/91; A-4006)
140.442	am	(P-12171/91; A-4006)
140.449	am	(P-12171/91; A-4006)
140.469	am	(P-13685/91; A-3552)
140.514	am	(P-11555/91; A-4006)
140.526	r	(P-472)
140.527	r	(P-472)
140.528	r	(P-472)
140.529	r	(P-472)
140.530	am	(P-15933/91; A-6408)
140.538	am	(P-15933/91; A-6408)
140.539	am	(P-472)
140.543	am	(P-3045)
140.552	am	(P-15933/91; A-6408)
140.561	am	(P-7482/91; A-3552)
140.562	am	(P-15933/91; A-6408)
140.565	n	(P-1492)
140.566	am	(P-4708)
140.569	am	(P-15933/91; A-6408)
140.579	am	(P-3409)
140.583	am	(P-15933/91; A-6408)
140.600	n	(P-472)
140.602	n	(P-472)
140.604	n	(P-472)
140.606	n	(P-472)
140.608	n	(P-472)

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140.610	n	(P-472)
140.612	n	(P-472)
140.614	n	(P-472)
140.646	am	(P-6949/91; A-1877)
140.835	r	(P-15933/91; A-6408)
144.275	am	(P-15926/91; A-5898)
144.300	n	(P-7455/91; A-3497)
144.325	n	(P-7455/91; A-3497)
144.350	n	(P-5806)
144.375	n	(P-5806)
144.400	n	(P-5806)
144.405	n	(P-5806)
144.425	n	(P-5806)
144.450	n	(P-5806)
147.25	am	(P-4218)
147.50	am	(P-4218)
147.75	am	(P-4218)
147.150	am	(P-15940/91; A-6479)
147.Tb. A	am	(P-7501/91; A-4035)
		(P-15940/91; A-6479)
147.Tb. B	am	(P-7501/91; A-4035)
		(P-15940/91; A-6479)
147.Tb. D	am	(P-4218)
147.Tb. E	am	(P-4218)
147.Tb. G	am	(P-4218)
147.Tb. L	am	(P-4218)
148.20	am	(P-15928/91; A-6255)
148.40	am	(P-15928/91; A-6255)
148.60	am	(P-15928/91; A-6255)
148.70	am	(P-15928/91; A-6255)
148.80	am	(P-15928/91; A-6255)
148.90	r	(P-15928/91; A-6255)
148.100	r	(P-15928/91; A-6255)
148.110	r	(P-15928/91; A-6255)
148.120	am	(P-15928/91; A-6255)
148.130	am	(P-15928/91; A-6255)
148.140	am	(P-1786) (P-15928/91; A-6255)
148.150	am	(P-15928/91; A-6255)
148.160	am	(P-15928/91; A-6255)
148.170	am	(P-15928/91; A-6255)
148.180	am	(P-15928/91; A-6255)
148.190	am	(P-15928/91; A-6255)
148.200	am	(P-15928/91; A-6255)
148.210	am	(P-15928/91; A-6255)
148.220	am	(P-15928/91; A-6255)
148.230	am	(P-15928/91; A-6255)
148.240	am	(P-15928/91; A-6255)
148.2650	am	(P-15928/91; A-6255)
148.270	am	(P-15928/91; A-6255)
148.280	am	(P-15928/91; A-6255)
148.290	am	(P-15928/91; A-6255)
148.300	am	(P-15928/91; A-6255)
148.310	am	(P-15928/91; A-6255)
148.320	am	(P-15928/91; A-6255)
148.400	n	(P-15928/91; A-6255)
149.5	am	(P-15931/91; A-6195)
149.25	am	(P-15931/91; A-6195)
149.50	am	(P-15931/91; A-6195)
149.75	am	(P-15931/91; A-6195)
149.100	am	(P-15931/91; A-6195)
149.125	am	(P-15931/91; A-6195)
149.150	am	(P-15931/91; A-6195)
149.175	r	(P-15931/91; A-6195)
149.200	r	(P-15931/91; A-6195)
149.205	r	(P-15931/91; A-6195)
149.225	r	(P-15931/91; A-6195)
149.250	r	(P-15931/91; A-6195)
149.275	r	(P-15931/91; A-6195)
149.300	r	(P-15931/91; A-6195)
149.305	r	(P-15931/91; A-6195)
149.325	r	(P-15931/91; A-6195)
150.10	n	(E-2258)
150.20	n	(E-2258)
150.30	n	(E-2258)
150.40	n	(E-2258)
150.50	n	(E-2258)
150.60	n	(E-2258)
160.5	am	(P-806/91; A-1852)
160.10	am	(P-806/91; A-1852)
160.20	am	(P-806/91; A-1852)
160.30	am	(P-2406)
230.45	am	(P-3605)
230.570	am	(P-3605)
240.400	am	(E-2630)
240.415	am	(E-2630)
240.430	am	(P-17007/91;M-2930) (E-17398/91; S-1744, W-2955; M-2943)
240.435	am	(P-17007/91; M-2930) (E-17398/91; S-1744, W-2955; M-2943)
240.655	am	(P-14335/91) (E-4069)
240.720	am	(P-17007/91; M-2930) (E-17398/91; S-1744, W-2955; M-2943) (E-2901)
240.725	am	(P-17007/91; M-2930) (E-17398/91; S-1744, W-2955; M-2943) (E-2901)
240.726	n	(E-2630)
240.800	am	(E-2901)
240.810	am	(E-2901)
240.825	am	(E-2901)
240.855	am	(E-2901)
240.1600	am	(P-4087)
240.1605	am	(P-4087)
240.1610	am	(P-4087)
240.1620	am	(P-4087)
240.1625	am	(P-4087)
240.1630	am	(P-4087)
240.1635	am	(P-4087)
240.1640	am	(P-4087)
240.1645	am	(P-4087)
240.1650	am	(P-4087)
240.1655	am	(P-4087)
240.1660	am	(P-4087) (C-5083)
240.1661	n	(C-5083)
240.1665	am	(P-4087)
305.10	#	(P-5403)
305.20	am	(P-5403)
305.30	am	(P-5403)
305.40	#	(P-5403)
305.50	am	(P-5403)
305.60	am	(P-5403)
305.70	n	(P-5403)
305.80	n	(P-5403)

TITLE 89 (CONT'D)

305.90	#	(P-5403)
305.100	#	(P-5403)
305.110	#	(P-5403)
305.120	#	(P-5403)
305.130	am	(P-5403)
305.140	#	(P-5403)
352.Ap. A	am	(P-13229/91; A-3924)
406.2	am	(P-14734/91) (E-15088/91; M-2269)
510.10	am	(P-69)
510.20	am	(P-69)
510.30	am	(P-69)
510.40	am	(P-69)
510.70	am	(P-69)
510.80	am	(P-69)
510.90	am	(P-69)
510.100	am	(P-69)
510.110	am	(P-69)
597.20	am	(P-3440)
674.10	n	(E-2690)
674.20	n	(E-2690)
674.30	n	(E-2690)
674.40	n	(E-2690)
674.50	n	(E-2690)
683.100	r	(E-2688)
685.500	am	(P-14392/91; A-4529)
685.550	n	(P-14392/91; A-4529)
714.30	am	(P-3067)
714.100	am	(P-3067)
714.110	am	(P-3067)
714.120	am	(P-3067)
714.130	am	(P-3067)
714.300	n	(P-3067)
714.310	am	(P-3067)
787.10	n	(P-13027/91; A-2882)
787.20	n	(P-13027/91; A-2882)
787.30	n	(P-13027/91; A-2882)
787.40	n	(P-13027/91; A-2882)
787.50	n	(P-13027/91; A-2882)
845.10	am	(P-11572/91; A-2615)
845.20	am	(P-11572/91; A-2615)
845.30	am	(P-11572/91; A-2615)
845.40	am	(P-11572/91; A-2615)
900.310	am	(P-12989/91; A-5311)
900.321	am	(P-12989/91; A-5311)
900.322	am	(P-12989/91; A-5311)
900.330	am	(P-12989/91; A-5311)
900.331	am	(P-12989/91; A-5311)
900.342	am	(P-12989/91; A-5311)
900.343	am	(P-12989/91; A-5311)
900.345	am	(P-12989/91; A-5311)
900.348	am	(P-12989/91; A-5311)
1300.110	am	(P-5141/91; A-4819)
1300.120	am	(P-5141/91; A-4819)
1300.130	am	(P-5141/91; A-4819)
1300.200	am	(P-5141/91; A-4819)
1300.205	n	(P-5141/91; A-4819)
1300.210	am	(P-5141/91; A-4819)

TITLE 92

44.30	am	(P-4807)
50.5	r	(P-6139)
50.10	r	(P-6139)
50.10	n	(P-6153)
50.20	r	(P-6139)
50.20	n	(P-6153)
50.30	r	(P-6139)
50.30	n	(P-6153)
50.40	r	(P-6139)
50.40	n	(P-6153)
50.50	r	(P-6139)
50.50	n	(P-6153)
50.60	r	(P-6139)
50.60	n	(P-6153)
50.70	r	(P-6139)
50.70	n	(P-6153)
50.80	r	(P-6139)
50.80	n	(P-6153)
50.90	r	(P-6139)
50.90	n	(P-6153)
50.100	r	(P-6139)
50.100	n	(P-6153)
50.110	r	(P-6139)
50.110	n	(P-6153)
50.120	r	(P-6139)
50.120	n	(P-6153)
50.130	r	(P-6139)
50.130	n	(P-6153)
50.140	r	(P-6139)
50.140	n	(P-6153)
50.150	r	(P-6139)
50.160	r	(P-6139)
50.Ex. A	n	(P-6153)
62.30	am	(P-4813)
171.6	am	(P-15995/91; W-2696)
171.6	#	(P-3856)
171.1000	am	(P-15995/91; W-2696) (P-3856)
172.2000	am	(P-16003/91; W-2697) (P-3864)
172.2215	am	(P-16003/91; W-2697) (P-3864)
173.3000	am	(P-16008/91; W-2698) (P-3869)
177.2000	am	(P-15990/91; W-2695) (P-3847)
178.336.1.1	am	(P-16015/91; W-2699) (P-3876)
178.336.1.5	am	(P-16015/91; W-2699) (P-3876)
178.2000	am	(P-16015/91; W-2699) (P-3876)
179.2000	am	(P-16027/91; W-2700) (P-3888)
180.2000	am	(P-3851)
391.2000	am	(P-16653/91; A-5362)
440.420	am	(P-13041/91; A-1655)
440.Il. A	am	(P-13041/91; A-1655)
440.Il. B	n	(P-13041/91; A-1655)
442.285	am	(P-13072/91; A-1685)
442.Il. A	am	(P-13072/91; A-1685)
442.Il. E	n	(P-13072/91; A-1685)
530.10	n	(P-2940/91; A-2193)
530.10	r	(P-3003/91; A-2256)
530.20	n	(P-2940/91; A-2193)

TITLE 92 (CONT'D)

530.20	r	(P-3003/91; A-2256)
530.30	n	(P-2940/91; A-2193)
530.30	r	(P-3003/91; A-2256)
530.40	n	(P-2940/91; A-2193)
530.50	n	(P-2940/91; A-2193)
530.60	n	(P-2940/91; A-2193)
530.100	n	(P-2940/91; A-2193)
530.101	r	(P-3003/91; A-2256)
530.102	r	(P-3003/91; A-2256)
530.103	r	(P-3003/91; A-2256)
530.104	r	(P-3003/91; A-2256)
530.105	r	(P-3003/91; A-2256)
530.106	r	(P-3003/91; A-2256)
530.107	r	(P-3003/91; A-2256)
530.108	r	(P-3003/91; A-2256)
530.109	r	(P-3003/91; A-2256)
530.110	n	(P-2940/91; A-2193)
530.110	r	(P-3003/91; A-2256)
530.111	r	(P-3003/91; A-2256)
530.112	r	(P-3003/91; A-2256)
530.113	r	(P-3003/91; A-2256)
530.114	r	(P-3003/91; A-2256)
530.115	r	(P-3003/91; A-2256)
530.116	r	(P-3003/91; A-2256)
530.117	r	(P-3003/91; A-2256)
530.118	r	(P-3003/91; A-2256)
530.119	r	(P-3003/91; A-2256)
530.120	n	(P-2940/91; A-2193)
530.120	r	(P-3003/91; A-2256)
530.121	r	(P-3003/91; A-2256)
530.122	r	(P-3003/91; A-2256)
530.123	r	(P-3003/91; A-2256)
530.130	n	(P-3003/91; A-2193)
530.140	n	(P-2940/91; A-2193)
530.150	n	(P-2940/91; A-2193)
530.200	n	(P-2940/91; A-2193)
530.201	r	(P-3003/91; A-2256)
530.202	r	(P-3003/91; A-2256)
530.203	r	(P-3003/91; A-2256)
530.210	n	(P-2940/91; A-2193)
530.220	n	(P-2940/91; A-2193)
530.225	n	(P-2940/91; A-2193)
530.230	n	(P-2940/91; A-2193)
530.240	n	(P-2940/91; A-2193)
530.250	n	(P-2940/91; A-2193)
530.260	n	(P-2940/91; A-2193)
530.270	n	(P-2940/91; A-2193)
530.275	n	(P-2940/91; A-2193)
530.280	n	(P-2940/91; A-2193)
530.290	n	(P-2940/91; A-2193)
530.300	n	(P-2940/91; A-2193)
530.301	r	(P-3003/91; A-2256)
530.302	r	(P-3003/91; A-2256)
530.303	r	(P-3003/91; A-2256)
530.310	n	(P-2940/91; A-2193)
530.320	n	(P-2940/91; A-2193)
530.330	n	(P-2940/91; A-2193)
530.400	n	(P-2940/91; A-2193)
530.401	r	(P-3003/91; A-2256)
530.402	r	(P-3003/91; A-2256)
530.403	r	(P-3003/91; A-2256)
530.410	n	(P-2940/91; A-2193)
530.420	n	(P-2940/91; A-2193)
530.430	n	(P-2940/91; A-2193)
530.440	n	(P-2940/91; A-2193)
530.450	n	(P-2940/91; A-2193)
530.460	n	(P-2940/91; A-2193)
530.470	n	(P-2940/91; A-2193)
530.480	n	(P-2940/91; A-2193)
530.500	n	(P-2940/91; A-2193)
530.501	r	(P-3003/91; A-2256)
530.502	r	(P-3003/91; A-2256)
530.503	r	(P-3003/91; A-2256)
530.510	n	(P-2940/91; A-2193)
530.520	n	(P-2940/91; A-2193)
530.530	n	(P-2940/91; A-2193)
530.600	n	(P-2940/91; A-2193)
530.601	r	(P-3003/91; A-2256)
530.602	r	(P-3003/91; A-2256)
530.603	r	(P-3003/91; A-2256)
530.610	n	(P-2940/91; A-2193)
530.700	n	(P-2940/91; A-2193)
530.701	r	(P-3003/91; A-2256)
530.702	r	(P-3003/91; A-2256)
530.710	n	(P-2940/91; A-2193)
530.800	n	(P-2940/91; A-2193)
530.801	r	(P-3003/91; A-2256)
530.802	r	(P-3003/91; A-2256)
530.803	r	(P-3003/91; A-2256)
530.804	r	(P-3003/91; A-2256)
530.810	n	(P-2940/91; A-2193)
530.820	n	(P-2940/91; A-2193)
530.830	n	(P-2940/91; A-2193)
530.840	n	(P-2940/91; A-2193)
530.900	n	(P-2940/91; A-2193)
530.901	r	(P-3003/91; A-2256)
530.902	r	(P-3003/91; A-2256)
530.903	r	(P-3003/91; A-2256)
530.904	r	(P-3003/91; A-2256)
530.905	r	(P-3003/91; A-2256)
530.906	r	(P-3003/91; A-2256)
530.907	r	(P-3003/91; A-2256)
530.908	r	(P-3003/91; A-2256)
530.909	r	(P-3003/91; A-2256)
530.Il. A	n	(P-2940/91; A-2193)
708.70	am	(P-8193/91; A-194)
787.10	n	(P-13027/91; A-2882)
787.20	n	(P-13027/91; A-2882)
787.30	n	(P-13027/91; A-2882)
787.40	n	(P-13027/91; A-2882)
787.50	n	(P-13027/91; A-2882)
1010.420	am	(P-5240)
1030.11	am	(P-1271)
1030.30	am	(P-2449)
1030.84	am	(P-14198/91; A-2182; C-2957)
1070.20	am	(P-15428/91; A-2172)
1070.40	am	(P-15428/91; A-2172)
1309.10	n	(P-3238)
1309.20	n	(P-3238)
1309.30	n	(P-3238)
1311.10	n	(P-4195/91; W-2942)
1440.20	am	(P-5139)

TITLE 95

116.40	am	(P-558)

TITLE 95 (CONT'D)

121.20	n	(P-561)
121.30	n	(P-561)
121.40	n	(P-561)
121.50	n	(P-561)
121.60	n	(P-561)
121.70	n	(P-561)
121.80	n	(P-561)
121.90	n	(P-561)
121.100	n	(P-561)
121.110	n	(P-561)
121.120	n	(P-561)
121.130	n	(P-561)
121.140	n	(P-561)
121.150	n	(P-561)
121.160	n	(P-561)
121.170	n	(P-561)
121.180	n	(P-561)
121.190	n	(P-561)
121.200	n	(P-561)
121.210	n	(P-561)
121.220	n	(P-561)
121.230	n	(P-561)
122.10	n	(P-2113)
122.20	n	(P-2113)
122.30	n	(P-2113)
122.40	n	(P-2113)
122.50	n	(P-2113)
122.60	n	(P-2113)
122.70	n	(P-2113)